12-03809 Chad Michael Heaps Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland /	Department of He	ealth and Mental	Hygiene

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ate of Maryland / Department of Health and Mental Hygiene	21	11	2		71		0
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		1- For State Registrar	Certificate	of Death		Re	2 U I	2 1100
Physicia edical Exami	ın/	Decedent's Name (First, Middle, Last)  Chad Michael Hea	ps			2. Date of Deat Month May 18, 20	Dav Year	3. Time of Death 1807 hrs
		4a. Facility Name (if not institution, give street and number) 169 Remington Road		4b. City, Town, or Port Depos		Death	4c. County of Death Cecil	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 220-17-4464 1XM 2FF	n yrs. last birthday) 28	If Under 1 Yea  Months Day  Yrs.	_	Min. May 8	th(MM/DD/YYYY) 9. Bir Foreig Co	thplace (State or In Mary land untry)
id how any ee.		Usual Residence of Decedent  10a. State 10b. County 10c  Maryland Cecil	c. City, Town or Loc		Depos	sit		10d. Inside City Limits 1 Yes 2 X No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 169 Remington Road		10f. Zip Code	2190		0g. Citizen of What Coul	
	Funeral	11. Marital Status  1 X Never Married  2 Married  3 Widowed  4 Divorced If Yes, Give Year		If Yes, specify Cuba		n? (Specify Yes or No- Puerto Rican, etc.)	White, etc.	can Indian, Black, White
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0-12) College (1-4 or 5+)	during	dent's Usual Occupa most of working life	ition (Give ki	se retired)	Boilermake Baltimore,	rs Local 193
15-003 filed withi I Hygiene. ed other th		Twelve Years  17. Father's Name (First, Middle, Last)  Curtis Michael Heaps				Name (First, Middle, M		
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medica</u>	To Be	19a. Informant's Name/Relationship (Type, Print)  Curtis Michael Heaps (fathe	19b. Mai			er or Rural Route Num	nber, City or Town, State	, Zip Code)
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:	crematory or	position (Name of ce other place) 11 Cemete		Date 05/22/12	20c. Location - City or Port Depos	
Baltir permit. J Departm Importa injury o		21. Signature of Funeral Servicer bicensee	1)6	Perrvvill	e, Mar	yland 2190	neral Home 03-0766	
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.  Immediate Cause (Final disease a. Methadone In	ıtoxicati					Approximate Interval Between Onset and Death
, /		or condition resulting in death)  Due to (or as a consequence of the conditions, b						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
executed an and al - transit		d.  X UNPENDED AMENDED23a,2	7,28a-f, <sub>1</sub>	per me,g92	28 6-1	-12 sm		
Box 68760, ceath certificate be executed the attending physician and effor use as the burial - trans	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of 1 Live birth 4 Pregnant at tim	2 🗌	Fetal death 3 Other (Specify)	Ectopic	pregnancy	23d. Date of deliver Month	y Day Year
	by Phy	Part II. Other significant conditions contributing to death but	ut not resulting in th	ne underlying cause	given in Part		bbacco use contribute to	
cords, law require has been si	Completed			-		24a. Was autop perfo 1 🗸 Yes	psy pnor to o rmed? death?	topsy findings available completion of cause of
ian: The certificate ector, page	BeC	25. Was case referred to medical		26.Plac		Check only one)		
Vita hysici this c	10 B	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient					Residence 6  Othe	r: Scene
n of ding P h. After		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Dey, Year)		1	uryatWork? Yes 2 🗶 I			
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: /	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury	12   td 5: - At home, farm, s  nd at Res	street, factory, office		28f. Location (3 or Town, 8	Street and Number or Ru State) 169 Remmi	
To the Hospi within 24 hou To the Fune completely fi	Medical C	29a. Certifier 1 Certifying Physician: To the best of my king one)  2 Medical Examiner: On the basis of examination and manner stated.	nowledge, death oc	ccurred at the time, o	date and place n, death occ	ce, and due to the caus	se(s) and manner as stat	ed. ne cause(s)
	Me	29b. Signature and title of centilier			se number .M.E.		29d. Date signed (Mo	nth, Day, Year)
CCME		30. Name and address of person who completed cause of deal Mary G. Ripple MD. Deputy Chief Medical	_	00 W. Baltimor	e Street,	Baltimore, MD 2	1223	
S Regis	tate		Signature	sike!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9 Day Physician/ May 20<sup>4</sup>72 13:05 PM Gilbert Paul Holmes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Elkton Care and Rehab E1kton Cecil Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 X M 2 □ F Nov. 8, <sup>Year</sup>1936 219-34-1177 Maryland Director 75 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1 Price Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or 1 Never Married 2 Married Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mobile Home other than Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked မ George Holmes Myrtle Shivery of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Holmes 108A Hollingsworth Manor, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Hart's Cemetery May 14. 1 XBurial 2 Cremation 3 Removal from State North East, Maryland 4 Donation 5 Other (Specify Crouch Funeral Home, P.A. 22. Name and Address of Facility 127 South Main Street, North East, Mryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After to d in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident 1 Yes 2 No Investigation within 24 hours after de

To the Funeral Directo

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nusse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWA2 SUITEA AUGUSTINE HERMAN HWY

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

CHESAPEAKE CIT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician HARVEY ROSE 2012 MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD HARFORD HUSPITAL MEMORIAL If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min Months 1 □ M 2 👿 F Director 142-30-5859 10/13/1939 New Jersey Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f sho Maryland Harford Havre de Grace 1 ☐ Yes 2 X No 10f, Zip Code 10e. Street and Number United States of 104 North Earlton Road 21078 America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status after 1 ☐ Never Married 2X Married 10 21215-0036 1 ☐Yes 2 No Specify Specify: White à 3 Widowed 4 Divorced Completed 16h, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than\* Elementary/Secondary (0-12) College (1-4or 5+) Toll Collector Civil Service Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Patrick Dovle Anna Nagy Injury or other traumatic ပ and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau John Harvey (husband) 104 N. Earlton Rd. Havre de Grace, MD 21078 Baltimore, 20c. Location - City or Town, State West Chester, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RA Ferris & Co Inc05/19/2012 Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S.Washington St., Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CAR CINOMA AN 910 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) □Yes 2√2No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 ☐Yes 2 ☑No Division of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Nation 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ball. D0058913 MAY 14 2012 MD Marricha

State Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARFORD MEMORIAL MOS PITAL 501

SOUTH UNION AVE, MANRE DEGRALE MARYLAND 21078

707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Helen MaRea Jones May 2012 4:53 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County

9. Birthplace (State or Foreign Country) 15 Blue Spruce Circle <u>Hagerstown</u> Year If Under 24 Hrs.
Days Hours Min 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours Months 213-20-8506 87 Pennsylvania **Director** 1 🗆 M 2 🗓 F Aug. 17, 1924 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State within 72 hours after death with the Maryland Director 1 Tyes 2 No Maryland Washington Co. Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 15 Blue Spruce Circle Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Federal Government Secretary traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ George Devilbiss Mary Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) it of Health a: If item 27 i Cynthia Murray / Daughter 17617 Burnside Ave., Hagerstown, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory May 15,2012 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Department of Important: If any injury or once. Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Fastern Blvd. N., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ etoste 0415 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Layes 2 M No 9 Unknown ate has been signed by the atter page 2 should be detached for 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed after death.

Director: After this certificate has 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending the f Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical langes MELON 31. Date filed (Mo

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY 2012 ROSE 2:30 PM Μ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. **Director** 421-42-7376 1 🗆 M 2 🗓 F 82 SEPT.22,1929 ALABAMA Usual Residence of Decedent 28a-f show 10a. State must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD. PRINCE GEORGE'S 1X Yes 2 No FT. WASHINGTON 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3108 ROSE VALLEY DR. 20744 U.S.A. "natural", or items Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed thand Mental Hygiene.
27 is marked other than "natural "matural" event, the Medical E. BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LIBRARIAN BOARD OF EDUCATION Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARTIN WILLIAM YANCEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE W. JONES JR./SON 3108 ROSE VALLEY DR., FT. WASHINGTON, MD. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Durial 2 Dremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 5-11-2012 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a conseque ce of): disease or condition Medical resulting in death) Examiner syncopal Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Advanced Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Yes 2 X funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A the Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ipletely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 87 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUGO 121250 Annapolis

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

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Dale

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Christine	Dawn	Jans
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		1- For State Registrar	c or maryland		ificate of L		id Wichie	ai riygiciic	Reg. No	. 21		2 1/01	U
Physicia	ın/	Decedent's Name (First, Middle,L	ast)					2. Date of De Month	Day	Year		3. Time of Death	
Medical Exami	ner	Christine Day 4a. Facility Name (if not institution,			Lab	City, Town, o	s Location of	May 4, 2		4c. County of	Dooth	0734 hrs	_
		Prince Georges Hospita				Cheverly	Location of	Death	- 1	Prince G		's	
Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Ye	ar If Under	24Hrs. 8. Date of I	Birth(MN	M/DD/YYYY)		place (State or	_
Director			M 2∑F	25	Yrs.	Months Da	ys Hours	Min. AUG 2	22,	1986	Foreigr Cou	ntry) CO	
any	-	Usual Residence of Decedent  10a. State  10b. County		10c. City, To	own or Location							10d. Inside City Limits	s
		MD Anne A	runde1	Gle	n Burni	e						1 Yes 2 X No	0
faryla	Director	10e. Street and Number			T.	Of. Zip Code			10g. Ci	itizen of Wha	at Coun	try?	
h the h		105A Oak Avenue				21061			Uni	ited S	tate	es	
6, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28s-f sho r traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Marri	12. Was Decedent Armed Forces? 1 X Yes 2		If Yes			n? ( Specify Yes or No Puerto Rican, etc.)	No-	14. Race - White,		an Indian, Black,	
after d	by F	3 Widowed 4 Divorce	ed If Yes, Give Year or Dates:	resent	t 1 7	es 2X No	o specify:			Specify: (	Cauc	asian	
hours natura	ed b	15. Decedent's Education (Specify	only highest grade con	noleted) 1	6a. Decedent's	Usual Occupa	ation (Give kine. DO NOT us	nd of work done se retired)	16b.	Kind of Bus	iness/(n	dustry	
36 in 72 l	Completed	Elementary/Secondary (0-12) 12	College (1-4 or	5+)	Cryptol			ian ′	Įτ	JS NAV	Y		
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e, MD 21215-003 land 2 should be filed withi Health and Mental Hygiene, item 27 is marked other th r traumatic event, the Med		Tina Victoria SI 20a. Method of Disposition	nirk / Moth		9541 ace of Disposition			ogan, OH		Location - 0	ity or T	'own State	_
Baltimore, MI Demit. Pages I and 2 s Department of Health a Important: If item 27	П	1 Burial 2 X Cremation	3 X Removal from Sta	cro	matory or other rer Vall	(appla)	100						
it. Pagirtment	H	4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	ify:		Cremato	rv ne and Addres	_ lu	5/17/2012	2   L	ancast	er,	ОН	_
Baltimore permit. Pages 1 Department of H Important: If it	d	Jul Ture	0/1300	M009	Th	ibadeau	ı Morti	uary Serv Gaithers	ice,	p.a.	ാറം	77	
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on			1 /	mode of dying	, such as card	diac or respiratory a	rrest, sh	nock, or hear	200 t	Approximate Interva Between Onset and	
/Medical Examiner	-	Immediate Cause (Final disease	a. Multiple Injuries									Death	'
Examiner		or condition resulting in death)	Due to (or as a conse	equence of):									
	5	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):							-		-
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ecuted and transit	Exal	events resulting in death) Last	Due to (or as a conse	equence of):							2.0		
ੂ ਜ਼ਿਲ੍ਹ	Medical	UNPENDED	AMENDED										
760, ficate be g physici s the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcon	ne of pregnar		death 3	Ectopic p	reanancy	23	3d. Date of d Month	elivery Da	ay Year	
Box 687 e death certific the attending i	ciar	past 12 months?	4 Pregnant at	time of death		death 3 (Specify)	Ectopic p	regriancy		WOTU	Da	iy real	
p.O. Box 687 that the death certific ned by the attending I detached for use as th	Physician/	1 Yes 2 No 9 V Unkno	3 Olikiowii										
P.O.	Ę,	Part II. Other significant condition	<ul> <li>contributing to death</li> </ul>	n but not resu	ulting in the und	erlying cause	given in Part I	"	_			ne cause of death?	
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COFC law re has be	Completed							auto	opsy formed?	pri		mpletion of cause of	
Rei The ificate		25. Was case referred to medical				20 Bl	f Dth (O	1 Yes	21	No 1 [	✓ Yes	2 No	_
Division of Vital Records, pital or Attending Physician: The law requirents after death.  reral Director: After this certificate has been similated in by the funeral director, page 2 should be	ă۱	examiner?	Hospital: 1 Inpatie	nt 2 🗸 Ef	R/Outpatient 3		Othor -	heck only one) Nursing Home 5	Resid	lence 6	Other:		-
of \ is Phy is Phy neral c	밝	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 2	8b. Time of Inju		ury at Work?	28d. Describe					_
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Spital bours nucral		4 Homicide determine 29a. Certification Physics	(Opening) Title					Ramp I-95 to	o MD 2				_
To the Hos within 24 h To the Fun completely	Medical	(Check only   Corulying Filya	an: To the best of my er:Or the basis of exar	/ knowledge, nination and/	, death occurred /or investigation	f at the time, d ı, in my opinioı	late and place n, death occur	e, and due to the car rred at the time, dat	use(s) a e and pi	nd manner a lace, and du	is stated e to the	I. cause(s)	
To To Com	Med	29b. Signature and title of certifier	and manner stated.			29c. Licens				Date signed			-
10+1		7///	( _			O.C.	M.E.		Ма	y 5, 2012	:		
OCME	ŀ	30. Name and address of pers wh				J							
			eputy Chief Medic				e Street, B	Baltimore, MD 2	21223				
Sta Regist		31. Date filed (Month, Day, Year) <b>RAY 1 4 20</b>		's Signature	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Physician/ 2012 3:30 PM May Nannie Jasper Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Regional George's Hospita Laurel Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) <sup>Country)</sup>Franklin Director 244-52-7740 1 M 2 F 10 18 1930 Yrs. 81 County, NC Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland **Funeral Director** notified 1 Yes 2 No MD Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be n 6801 Bock Rd. Apt. 204 20744 United States items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black "natural" Completed 3 Midowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the Cafeteria Worker 16yrs. Federal Government Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, tt. once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Page 1 and 2 should be Archie Durham Annie Wilder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Hall/ Granddaughter 2508 Lilymount Dr. Raleigh NC 27610 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Porial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Denation 5 Other Specif Maryland National 5-14-2012 Laurel, Maryland 22. Name and Address of Facility John T. Rhines Funeral Home Now 3005 12th Street NE Washington DC 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Pnysician Encephalo path disase or condition resulting in death) Medical Due to (or as a consequenc of): **Examiner** Acidosis Sequentially list conditions Examine in any, leading to immediate cause. Enter Underlying End Stage Rena the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? Yes 2 No this certificate 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၟႍ 1 Yes 2 No 1 🗶 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , mo 05 D71264

DHMH 17 Rev 06-2011

Registrar

VAN DUSEN RD SUITE 220 LAUREL, MID 20707

30. Name and address of person who completed cause or death (Item 23a) (Type, Print)

7350

32. Registrar's Signature

UNEGBUIME

31. Date filed (Month, Day, Year)

MAY 1 4 2012

			Please Type or P amend #20b Per State of i	rint in Black FH G928 6 Maryland / De	<b>( Indelible In</b> /12/2012 J epartment of I	<b>k. Ensure A</b> h Health and M	<b>III Copies</b> Iental Hvo	s Are Legible giene	<b>).</b>
			State     Registrar		Certificate of			Reg. No. 201	2 17008
	Physicia Medi		1. Decedent's Name (First, Middle, Last)  James C. James	·			2. Date of Dea Month	Day 20 Year	3. Time of Death
	) Examir	ner	4a. Facility Name (if not institution, give street and number)			or Location of Death	00	4c. County of De	ath
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	aryland a-f show fied at	ector	10a. State 10b. County  MARYLAND HARFORD	10c. City, Town or					10d. Inside City Limits
	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at.	Funeral Director	10e. Street and Number	-	10f. Zip Code	DE GRACE		10g. Citizen of What C	1 Yes 2 □ No Country?
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ဖွ	ter dea	by Fu	11. Marital Status 1 ☐ Never Married 2 💢 Married 12. Was Deceden Armed Forces 1 📈 Yes 2 €	?		an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
765 C. 21215-0036	ours af atural" cal Exa	eted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1968-76	1 Yes 2 X No	. ,		Specify: B	LACK
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	ed within Hygiene. other tha ent, the I	Be Co	17. Father's Name (First, Middle, Last)		OMBAT ENGI	<u> </u>		US MARIN	ES
Maryland	0 = 0	10	MEDFIELD JAMES			18. Mother's Name		Maiden Surname)	
Mary	shou and is m		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, 2	
	and Heal tem		SHARON Y. JAMES / WIFE 20a. Method of Disposition	20b. Place of Di	isposition (Name of			DE GRACE, 1 20c. Location - City of	
Baltimore,		П	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, o	or ematory or other place ON NATIONAL		<sup>Date</sup> <del>UNK</del> /2012	ARLINGTON,	
a	permit. Page Department ( Important: II any injury or		21. Signature of Funeral Service Licensee	2200	22. Name and Addre	ess of Facility COTT FUNE	RAL HOMI	. P.Δ.	
Ian			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li	ed the death. Do not	552 LE	WIS STREET	r, HAVRI	DE GRACE	Approximate
	Physician/		Immediate Cause (Final disease or condition resulting in death)	rona	ry a	rter	e oli	-caze	Interval Between Onset and Death
DAY	Medical Examiner		Due to (or a	a consequence of):	1 11	10 20	ety	,	
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Rox 68	death c he atten ed for u	siciar	in the past 12 months?  1   Live Birth 1   Yes 2   No	2 Fetal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of de Month	elivery Day Year
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S, P	requires that the death certificate to been signed by the attending phys should be detached for use as the	ed by		but not resulting in th	e didenying cause gr	veri iti Fait I.	1 $\square$ Y	pacco use contribute t es 2 ∰No 3 □ F	o the cause of death?  Probably 4 🗆 Unknown
cord	aw requas beer 2 shou	Completed					24a. Was a	24b. Were a	utopsy findings available completion of cause of
Rec	sician: The law rescribed as the sector, page 2 s						perform 1 Yes	ned? death?	s 2 No
Vita	ysiclar s certif directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 □ No	tient 2 🗆 ER/Outpa	Oth	er:		ence 6 🗆 Other (Spe	-7.5
Division of Vital Records,	ing Phy Viter thi uneral		27. Manner of Death  1 Natural 5 Pending (Month, D	ury 28b. Time	e of 28c. Injury	y at 2		w injury occurred	ory)
sior	Attend r death ector: A	Certificate:	2 Accident Investigation	jury - At home, farm,		Yes 2 □ No	P8f Location /St	reet and Number or Ru	ıral Route Number
Divi	ital or urs afte ral Dire		building, e	tc. (Specify)			City or Town	, State)	
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or inv	estigation, in my opinic	on, death occurred at t	he time date an	d place, and due to the	cause(s) and manner stated
	To with		29b. Signature and title of certifier	elore	29c. License	00217	77 2	9d. Date signed (Mont	h, Day, Year)
5+	IVA		30. Name and address of person who completed cause of	death (Item 23a) (Type		1000 Sic#	m On	na Point	MD21902
	Stat Registra		31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	barka!	niegsie	my per		MACHA
	1109151116		MULT TO CALL TOWN	same be .	7				

12-03746 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Joseph Melvin Kyle, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 16, 2012 Joseph Melvin **Medical Examiner** Kyle Jr. 1102 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 21416 Creek Side Drive Westernport Allegany 5. Social Security Number 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 219-76-0397 Foreign W**esst**uy)Virginia Director 54 Months Days Hours Min. 07/29/1957 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Westernport items 23a or 28a-f show ust be notified at once. MD Allegany 1 Yes 2 X No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
and: If item 21 is marked other than "natural", or items 23a or 28a-f sho and: If item 21 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21416 Creekside Drive 21562 United States 喜 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 1 Yes white 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) trucking mechanic 21215-0036 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Joseph Melvin Kyle Sr. Dorotheymae Blye 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M 21416 Creekside Drive, Westernport MD 21562 Terry Lynn Kyle/wife ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Cumberland Crematory 1 Burial 2 Cremation 3 Removal from State 05/21/2012 Cumberland Maryland Baltimo
permit. Page:
Department o
Important: injury or oth 4 Donation 5 Other Specify: 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 7. Warre 111 Church St, Westernport, Maryland 21562 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical AMENDED 23a, pt. II, 27, per me, g928 6-1-12 sm g physician the burial -X UNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P. 0. 23e. Did tobacco use contribute to the cause of death? <u>る</u> 1 Yes 2 No 3 Probably 4 Unknown Chronic Alcohol Abuse Completed Records, certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical of Vital 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene this ER/Outpatient 3 DOA 1 🗸 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division I Director: Pending 1 Yes 2 No 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be To the Hospital or within 24 hours at To the Funeral I determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 17, 2012 monly Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) ack Registrar

DHMH 17 Rev 1/2001 OCME 2006

**OCME** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10° May 2012 12:10 A M Paul Walter Kolody Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 0272271949 New York Director 130-38-0141 63 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No Anne Arundel Maryland Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3121 Fern Hill Court 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ٥ Š 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ould be filed within 72 Ind Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Mechanical Engineer Defense Be 17. Father's Name (First, Middle, Last) ermit. Page 1 and 2 should be filed epartment of Health and Mental Haportant: If item 27 is marked other yinjury or other traumatic eventy injury or other traumatic eventy. 18. Mother's Name (First, Middle, Maiden Surname) ျှ Walter Kolody Katherine Butscher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Kolody / Wife 3121 Fern Hill Court, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State 5-13-2012 4 Donation 5 Other (Specify) Kalas Crematory Edgewater, MD permit.
Der artn
Importa
any inju Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1 Epwer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated as in the cause (Disease or iinjury that initiated as in the cause (Disease or iinjury that initiated as in the cause (Disease or iinjury that initiated as in the cause (Disease or iinjury that initiated as in the cause (Disease or iinjury that initiated as in the cause (Disease or iinjury that initiated as in the cause of the cause o Examiner Due to (or as a consequence of): as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Box 68760 IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2/1 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: 1 \sum Yes ပ 1 Minpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I the only one 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

				ype or Print in B					-		egible.		
			- State 5/14/2012 AACO H	State of Maryland		tificate			F	Reg. No.	2012	2 170	
	Physicia Medio		1. Decedent's Name (First, Middle, Last)  Jane Reynold						2. Date of Dea May 10,		Year	3. Time of Death 9:15 P	
	Examin	er	4a. Facility Name (if not institution, give str Hospice of Queen					Location of Death			en Anr		
	Funeral Director		5. Social Security Number 219-10-9477  Usual Residence of Decedent	7. Age (In yrs. las	t birthday) Yrs.	If Under Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/6/192	Year)	_Cou	nplace (State or Fore ntry) nnsylvania	-
	faryland Ba-f show tified at	Director	10a. State 10b. County Naryland Queen Ann	ie's	Town or Loc	cation	Ches	ter				10d. Inside City Lim	
	with the Ns 23a or 2 ust be no	Funeral Dii	10e. Street and Number 6016 Bridgepoint	Drive		10f. Zip	Code	21619			of What Cou USA	untry?	
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 <b>X</b> Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1* Yes 2 No If Yes, Give Year or Dates. WWI	If	Vas Deced Yes, spec	cify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Amer Black, White cify:		
215-(	n 72 hou e. ian "nati Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		life, DC	ind of wor NOT use	rk done di e retired)	uring most of work	ing		of Business I	-	Ш
2	iled within Il Hygiene. I other tha	Be C		4	Regi	stere	ed Nu	· · · · · · · · · · · · · · · · · · ·			lic He	ealth	
ylanc	12 should be filed lith and Mental Hy 27 is marked oth r traumatic event	To E	17. Father's Name (First, Middle, Last) Clarence Eugene					18. Mother's Nam Jennie	Irene Pa			_	
Baltimore, Maryland 21215-0036	1 and 2 shoul of Health and I ifem 27 is ma other traums		19a. Informant's Name/Relationship (Type Susan Gilhooly -	Executor	19b. Mailin 401	1 Bri	dgep	nd Number or Rur vint Dr, nte Dr	al Route Number, Chester	, MD	21619		
imore	permit. Page 1 a Department of H Important: If ite any injury or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cer	ice of Dispos netery, crem land	natory or o	ther place	e) :	Date 6/2012		on-City or imore		
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee	Wholes X				s of Facility Jo f Glouce		•		al Home , MD 21401	
-	Trysician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	Do not ente	r the mode	e of dying	, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequen	nce of):	LEN						<u> </u>	
	ted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury	Due to (or as a consequen	nce of):								
0	e be executed ysician and e burial-transit	<del> </del>	that initiated events resulting in death) Last	Due to (or as a consequen	nce of):								
. Box 68760	Or the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and for the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-train	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 □X No 9 ☐ Unknown	c. If yes, outcome of pregnanc 1  Live Birth 2  Fetal of the Pregnant at time of dec 9  Unknown	death 3 🗌	Ectopic p		,		23d.	Date of deli	very Day Year	
ls, P.O.	uires that the signed by the s	2	Part II. Other significant conditions control	ributing to death but not result	ting in the ur	nderlying o	cause give	en in Part I.				the cause of death?	wn
Division of Vital Records,	iician: The law rec certificate has bee rector, page 2 sho	Completed							24a. Was a autops perform	med?_	prior to codeath?	opsy findings availab ompletion of cause o 2 🗆 No	le if
/ital	sician s certif lirector	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient 2 ☐ El	P/Outpatient	+ 2 □ DC	Other	ce of Death (Chec	k only one) ome 5 $\square$ Reside	6 0	Other (Conni	Hospice	-
on of \	nding Phy ath. : After this e funeral c		27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		8b. Time of injury		8c. Injury work?	at	28d. Describe ho			CENTER	-
Division	al or Attending P s after death. Il Director: After t id in by the funera	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory	, office		28f. Location (St City or Town		mber or Rura	al Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical Examine)	an: To the best of my knowled: On the basis of examination a Practioner: To the best of my k	and/or investi	gation, in r	my opinior	n, death occurred a	t the time, date an	d place, and	due to the ca	ause(s) and manner st	ated.
	To the within 2 To the Comple		29b. Signature and title of centifier			29c.	D63	number 3747	2	9d. Date sig	ned (Month,	Day, Year)	
11	HEIL		30. Name and address of person who com					1	CENTR	//-	100	21617	
	Stat Registra	·C	31. Date filed (Month, Day, Year)  MAY 1 4 20	32. Registrar's Signatur	540 B. A	barks	1	110 1404)	CGMIL	51/12	rvy	-/0//	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

leagan Ruth Ka	arn	St 1- For State Registrar	tate of Maryla		artment o <i>rtificate</i> o		d Mental		20 l	2 1701
Physicia Medical Exami		Decedent's Name (First, Midd     Meagan Ruth		_			•	2. Date of Dea Month May 19, 2	ath Day Year	3. Time of Death 2024 hrs
		4a. Facility Name (if not institution Carroll Hospital Center	on, give street and nur	mber)		4b. City, Town, or I			4c. County of De	eath
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days		Min.	irth(MM/DD/YYYY) 9.	Birthplace (State or reignWashington Country) DC
		216-19-2162 Usual Residence of Decedent	1 M 2XF	28	Yrs			April	10,1984	
ind show any ace.	'n	Maryland Cari	roll		Town or Locat					10d. Inside City Limits  1 Yes 2 No
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number				10f. Zip Code	7.1		10g. Citizen of What C	•
th with the terms 23a at be notif	Funeral [	410 South Main  11. Marital Status  1 X Never Married 2 Marital		edent Ever in U		217 as Decedent of Hisp es, specify Cuban,	anic Origin?	( Specify Yes or No erto Rican, etc.)	United S 0- 14 Race - An White, etc	nerican Indian, Black,
s after dea ral", or it	by	3 Widowed 4 Div	orced If Yes, Give Year		1 🗆	Yes 2 No			Specify: Wh	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Completed	15. Decedent's Education (Spe- Elementary/Secondary (0-12)	College (1-		during m	nt's Usual Occupationst of working life.	DO NOT use		16b. Kind of Busines	
ore, MD 21215-0036 set and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than ther traumatic event, the Medical	Com	12 17. Father's Name (First, Middle,	Last)		Нот	se Handl		ame (First, Middle,	Horse Fa:	rm
2121 ald be fil Mental F narked		Robert J. Karn 19a. Informant's Name/Relations			19b. Mailine	Address (Street	Chery1	M. Levat	tich mber, City or Town, St	ate Zin Code)
MD id 2 shot ulth and ] in 27 is n	-	Robert J. Karn			410 S	outh Mai	n Stre	et, Mt. A	Airy, Mary	land 21771
5 - S - S - S - S - S - S - S - S - S -		20a. Method of Disposition  1 Burial 2 X Cremation		m State	crematory or ot			Date	20c. Location - City	or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		21. Signatur Funeral Sovice		11	/ 22. N	lame and Address	of Facility			
Physician	Н	23a. Part I. Enter the disease, or failure. List only one cause	complication, that car	used the death	. Do not enter the	ne mode of dvina, s	such as cardia	ac or respiratory an	rest, shock, or heart	aryland 21702 Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		Use		ation and	i Naice	oric (Her	om) and	Death
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c							-
D,  be executed sician and ourial - transit	edical E	X UNPENDED	d	3a,27,	28a-f.p	er me,g92	28 6-5-	-12 sm		
Eri. Gi.	/Med	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, ou	utcome of preg	nancy				23d. Date of deliv	•
Box 68760, ne death certificate be extremely the attending physician reference for use as the burial red for use as the burial	Physician/M	past 12 months? 1 Yes 2 No 9 ✓ Unk	4 Pregna	nt at time of de	oth ~ 🖂	tal death 3 L her (Specify)	_Ectopic pre	gnancy	Month	Day Year
P.O. B	by Phy	Part II. Other significant conditi			esulting in the u	inderlying cause giv	ven in Part I.			to the cause of death?
aw requires has been sign 2 should be								24a. Was	an   24b. Were	autopsy findings available o completion of cause of
of Vital Records, ag Physician: The law require the three this certificate has been signeral director, page 2 should be	Completed								rmed? death	?
Vital Rec ysician: The I his certificate I director, page	å	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	111-111	patient 2	ER/Outpatient		of Death (Che	<del></del>	Residence 6 Ott	ner:
r of viding Ph. h After t	on: To	27. Manner of Death  1 Natural 5 Pend		f Injury Day,Year)	28b. Time of Ir		at Work?	28d. Describe	how injury occurred	
Division tal or Attendit rs after death. al Director: A	Certification:	2 Accident Inves 3 Suicide 6 X Could	atigation 28e. Place			pm   t, factory, office bu ked vehic	ilding, etc.	28f, Location (	Street and Number or	Rural Route Number, City olly Pine Cir
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying Ph	nysician: To the best	of my knowled	ge, death occur	red at the time, date	e and place,	and due to the caus	se(s) and manner as st	ated.
To th within To th	Medical	29b. Signature and title of certifier	and manner sta		nd/or investigat	29c. License		ed at the time, date	and place, and due to	
		(Caluber	D			O.C.M	l.E.		May 20, 2012	
			who completed cause ssistant Medical			ltimore Street,	Baltimore	e, MD 21223		
Sta Registi		31. Date filed (Month, Day, Year)	3 2012 32. Red	istrar's Signatu	re Ø. 49	arke				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20°1′2 10:57 P M 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9206 Villa Dr Bethesda Montgomery Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F Hours 08767771950 Country) Director 215-54-6006 61 Yrs D.C. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9206 Villa Dr 20817 USA 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Specify: White Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ gold miner gold mining other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ John B. Kirks, Jr. Katharine K. Koester Page 1 and 2 should 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 9206 Villa Dr., Katharine K. Kirks/mother Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Brown's Cemetery 05/11/2012 Foxville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 23a. Part 1. Enter the disea e, or complications (1) it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -ard-unilmomy disease or condition Medical resulting in death) Examiner DESTENDION Sequentially list conditions, if any hading to immediat cause. Enter Underlying Examir ZNIC Dirordi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: \ within 24 hours after death. To the Funeral Director: After this certifics 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Accident Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year) 34680 of death (Item 23a) (Type, Print) 33~ ST#136 BAZINIEL MD 200 3

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9:10a <sub>M</sub> 2. Date of Death Physician/ Charles Ray Kelley Maty 10,2012 Medical c. County of Death Washington 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Williamsport Twin Oaks Assisted Living Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Maryland 217-28-7281 85 100-1764 1926 Director 1**X** M 2 □ F show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. Count 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hagerstown 1X Yes 2 □ No 10e. Street and Number 1417 Kensington Dr. 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Vas Decedent Interpretation of the Interpret If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White etc. white by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) truck mfg.co Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) parts purchaser Be Father's Name (First, Middle, Last)
Charles William Kelley 18. Mother's Name (First, Middle, Maiden Surname) 2 Laura Royalston Shank 19a\_Informant's Name/Relationship (Type, Print) Joyce Whittington daughter Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
O Longmeadow Rd. Hagerstown, MD 20a. Method of Disposition 20c. Location - City or Town, State Clear Spring, 20b. Place of Disposition (Name of 5-15<sup>ate</sup> 2012 1X Burial 2 Cremation 3 Removal from State St. Paul Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen <sup>22</sup>Donald Edwin Thompson Funeral Home, Inc 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final ENDSTAGE CNGESTIVE HEART PAILLIPLE Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis etellibrial to by the funeral director, page 2 should be detached for use as the burnels filled. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No မ 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 3700 11.6 SHIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 154 HETIZAN ST egistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Frederick Kerler, Jr. May 14 2012 2:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2 DF Hours Month, Day, 220-30-6392 78 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10510 Brighton Rd. 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married þ 1 X Yes 2 ☐ No If Yes, Give Kerler, Charles Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yes Specify. Specify: white "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lith and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Draftsman Westinghouse Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles F. Kerler, Sr. Agnes Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Delizia Kerler/wife 10510 Brighton Rd., Ocean City, MD 21842 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State Eastern Shore Vet. 5/18/2012 Hurlock, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Fune Service Licenses any 108 William St., Berlin,MD 21811 Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on each aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Ente Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma Physician/ Squamous Cell disease or condition Medical resulting in death) Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? perform certificate 1 Yes 2 No Yes 2 XNo Division of Vital 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death Funeral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a Certifier within 24 hor To the Fune completed fi Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) R 135131 May 15, 2012

DH 10+1

State Registrar

DHMH 17 Rev 7/2009

Registrar

9715 Healthway Dr, Berlin, MD

21811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

CRNP,

Pennie Savage,

MAY 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #11 per spouse G930 8/30/12 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **05**<sup>Day</sup> Physician/ MAY CHRISTOPHER A. KILLIAN 2012 1:00 AM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 107 ELM STREET STEVENSVILLE QUEEN ANNE'S Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Min **Director** 170-44-8615 1 X M 2 🗆 F 45 Yrs JULY 14,1966 PENNSYLVANIA Usual Residence of Decedent 28a-f shov 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 ELM STREET 21666 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian þ 1 Never Married 2 Married Black, White, etc. ☐ Yes 2 💢 No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 H Div Specify: Year or Dates WHITE 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) MARINE CONSTRUCTION TUG BOAT CAPTAIN event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDERIC KILLIAN, SR. JANE ARNOTT other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau FREDRIC KILLIAN, JR./BROTHER 107 ELM STREET, STEVENSVILLE, MD 21666 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION CENTER 4 Donation 5 Other (Specify) STEVENSVILLE, MD 2012 Signature of Pune Arvice Licen FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) GARLE Medical Due to ( as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) ó in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death should be detached signed by the 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 performed this certificate 1 Yes 2 No Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 🔀 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death. 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UKERS mo TEPPRET 2540 ConTreville 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY Registrar B. Sparke

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State		State of	Mary	and / Dep	artmen	t of H	lealth	and N	Mental Hy	giene			
				Registrar					rtificate					Reg. No.	0.0	112	1701
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	Exan			4a. Facility Name (if not i	nstitution, gi	ive street and numbe	r)		4b. City, T	own, or	Location of	of Death	ITAL			of Death	5:10P M
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21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at.	Completed		15	Decedent's	Year or Dates								s	pecify:	WHIT	E
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and	e filec ntal H ed ott	To Be	9	17. Father's Name (First, I									(First, Middle, I		rname)		
Maryland	d Mer mark matic	-	ŀ	WILLIAM			SR.				MAR	GAR	ET IS	BEL	LE	PUTN.	AM
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E O	age ent o			1 Donation 5 D	mation 3	Removal from Stat	e	Place of Dispos cemetery, crema	atory or othe	r place)		AY D				City or Town	
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-	Medical Examiner	_		esulting in death)		a. Due to or as	a donse	- 1		.//	7 11						
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89	ss that the death certificing igned by the attending be detached for use as	Physician/N		FEMALE: Bb. Was decedent pregna	nt I	23c. If yes, outcome	of pregn	ancy									
Вох	death le atte	Sicis		in the past 12 months'	·	4 🖳 Pregnant a	2 Fet t time of	al death 3 E death 5 E	ctopic preg	nancy				230	Date of Month	of delivery Day	/ Year
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σ.	Attending Physician: The law requires that the death certif re death.  **r death.**  **ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a constant.	2	Pa	art II. Other significant co	onditions co	ontributing to death b	ut not re	sulting in the und	erlying caus	e given	in Part I.		23e. Did toba	acco use	contribu	te to the ca	use of death?
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ita	lysician: is certific director,	Be	25	. Was case referred to me examiner?	-	loon tel			26	6. Place	of Death (0	Check or		No.	1 _	Yes 2	J No
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ט ט	th. After funer	cate		1 Natural 5 🗆 F	ending	28a. Date of injui (Month, Day	y Year)	28b. Time of injury	V	njury at vork?		280	l. Describe how				
isio	after death Director: / d in by the	Certificate:		3 ☐ Suicide 6 ☐ C	vestigation ould not be	28e. Place of Inju					2 No						
Division of Vital Records,	= <b>1</b> # d			4 - Homiciae d	etermined	building, etc	(Specify	) )	factory, offic	ce		28f	Location (Stre City or Town,	et and Nu State)	mber or	Rural Rou	te Number,
	or are mospital or Attending Ph within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	Medical	29	a. Certifier 1 Cert	fying Physi	cian: To the best of er: On the basis of ex	ny knowl	edge, death occi	irred at the t	time da	te and place	e and a	lue to the same	0(0) == -1			
14	the F	Me		(Check 2 Med only one) 3 Cert	ical Examin fying Nurse	er: On the basis of exe Practitioner: To the	amination best of n	n and/or investigat ny knowledge, dea	ion, in my op	pinion, de at the tir	eath occurr	ed at the	time, date and	place, and	due to t	s stated. the cause(s)	and manner stated.
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- <del></del> -	( )I	7	%. **	Name and address of pe	son who co	mpleted cause of de	ath (Item	23a) (Type, Print)	· /	,	1- 1	2	1	100	1	4 A 1 A	1 1 1 1 1 1 1
	State		31.	Date filed (Month Day Ve	ar) SCI	M 5400	1	2111	asl	wi	m 1	wa	JV	alk	NY	MD	20004
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12-03741 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Keith Andrew Loetz State of Maryland / Department of Health and Mental Hygiene 1-For State AMEND#4a Per ME OFFAUTH DEPT Mertificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day May 16, 2012 **Medical Examiner** Keith Andrew Loetz 0625 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 943 Burnette Avenue 943 Burnett Avenue Anne Arundel 9. Birthplace (State or ForeignMary Land Country) 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Davs Hours Director 213-02-5156 47 04/12/1965 1 X M 2 F Usual Residence of Decedent 10d Inside City Limits 10a State 10b County 10c. City. Town or Location 1 Yes 2 X No MD Anne Arundel Arnold . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, are the first if the 27 is marked other than "natural", or items 23a or 28a-f sho or other traumaite event, the Medical Examiner must be anotified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 943 Burnett Avenue 21012 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Never Married 2 Married Yes White 4 X Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automotive Baltimore. MD 21215-0036 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John Francis Loetz Patricia Lee Grube Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Lee Loetz/ Mother 943 Burnett Avenue Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 21 1 X Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park Cemetery Glen Burnie, MD 2012 Donation 5 Other Specify: 22 Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy, 21. ensemble of uneral Service Lisensee Severna Park Funeral Home Severna Park, MD 21146 **Physician** af I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Narcotic, Cocaine, and Alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last hysician/Medical AMENDED 23a, 27, 28a-f, per me, g928 6-5-12 smX UNPENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **会** 1 Yes 2 No 3 Probably 4 V Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes this 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Fuoeral Director: A completely filled in by the fu 1 Natural 1 Yes 2 X No 5 Pending unknown fd 5-16-12 fd 6:14 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) 943 Burnett Ave. Arnold, MD. Found: Residence determined 4 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician:

31. Date filed (Month, Day) State Registra

29b. Signature and title of certifier

Laron Locke MD.

uterry

30. Name and address of person who completed cause of death (Item 23a)

4 2012

OCME

istrar's Signature

and manner stated

Assistant Medical Examiner

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

May 17, 2012

A	MEND #	27	PER MD G9	Plea 7/5	712	pe or FRT State o	<b>Prin</b> of Ma	<b>t in l</b> rylan	Black I d / Dep	<mark>ndeli</mark> l artme	<b>ble Inl</b> ent of F	<b>k. Ens</b> Health :	<b>ure A</b> and M	<mark>II Copie</mark> Iental Hy	s Are	e Leg	ible.			
			For State Registrar  1. Decedent's Name						Ce	rtifica	te of L	Death			Reg. N	0.21	112	)	17	019
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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	<ul><li>11. Marital Status</li><li>1 Never Marr</li><li>3 Widowed</li></ul>		ried	Was Dece Armed Fo 1 ☐ Yes If Yes, Giv	orces? 2 <b>∑</b> N ∕e		I			dispanic Origan, Mexicar  Specify:		cify Yes or No Rican, etc.)	-		e - Amer ck, White		dian,	
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- H	sician: The law is certificate has the lirector, page 2 s		25. Was case referr	ed to medical	-						26. P	Place of Dea	th (Check	1 \( \text{Yes} \)	200	Vol	1 L Yes	2 🗆	No	
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Division of	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could deterr			e of Injur ling, etc.		ome, farm, st	reet, fact	ory, office			28f. Location City or To			er or Rui	ral Rout	te Numb	er,
	e Hospi 24 hour e Funera leted filk	Medical	(Check 2	Medical	Examiner	On the ba	sis of exa	aminatio	n and/or inve	stigation,	in my opini	ion, death o	ccurred at	d due to the of the time, date ce, and due to t	and place	ce, and du	e to the o	cause(s)	and ma	nner stated.
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A	H 12		30. Name and addr	ess of person	who com	oleted cau	se of de	ath (Item	23a) (Type,	Print)	Gero	11 9	7.	50/is	550	/ 7 .	MI	צו ר	113	01
	Sta Registr		31. Date filed (Mont	MAY 1	5 201	2 32.	egistrar	's Signa	turel. A	bark	V			,,,,		//				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day Month 5 2012 5:55 pm Jose Arturo Lizama Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours 129th 9 1 9 6 3 Director 213-15-3403 49 1X M 2 D F Yrs sidence of Decedent Salvador 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Rockville Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 13002 Evanston Street 20853 must b United States 11 Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Completed by ō 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 √ Yes 2 No Specify: Salvadoran If Yes Give "natural" Specify: White 3 Divorced 4 Divorced other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Warehouse driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jose Pablo Lizama Maria Morena Portillo de Lizama and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Osael Lizama - son 13002 Evanston St., Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial 5/12/12 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home Wanda C. Bacon CC0361 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastic Sarcoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events burial tran resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death g Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕇 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural work? 5 Pending injury 2 Accident
3 Suicide Investigation mpletely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier Jayanti 0052586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jayanti 8600 Old Georgetown Rd., Bethesda, MD 20814 MD31. Date filed (Month, Day, Year, State MAY 14 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Grant William Lowe 4:49A Medical Examiner 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 6240 Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Davs Hours Min. Country Director Yrs 4, None 19 2012 Maryland May Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Marvland Montgomery Dickerson 10e. Street and Numbe ō 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be Funeral 18608 Wasche Road 20842 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 🔀 No 1 ☐ Yes 2 🔀 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: White Year or Dates WILLIAM the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Infant traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 1 and 2 should be filed if Health and Mental Hitem 27 is marked ot 18. Mother's Name (First, Middle, Maiden Sumame) ည Tony Lowe Jessica Lee Crawford GRAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Lee Crawford - Mother 18608 Wasche Road Dickerson, MD 20842 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o οę 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 13 Lincoln Crematory 05/15/2012 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitSimple Tribute Funeral & Cremation 1040 Rockville Pike, Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final extreme Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year should be detached Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 D-No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 The Natural 5 Pending work' Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 34098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monglond Kambiz Kazemi,MD Doctors Germm town, Drive, 19514

State

Registrar

31. Date filed (Month, Day, Year)

1 5 2012

State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14, 2012 7;20 A M Eda LEVITINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Montgomery Hospice Casey House If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 017-26-3720 Director 1 🗆 M 2 💢 F 85 Feb. 16, 1927 Russia ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 420 Pershing Drive 20910 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white "natural" Completed 3 X Widowed 4 □ Divorced Specify: f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Professor College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Bronia Louis Mazer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8214 Stone Trail Drive, Bethesda, MD 20817 Annette Woodside, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott → Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 05/16/12 Adelphi, MD 4 Donation Tother (Specify) Torchinsky Hebrew Funeral Home Pat 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sediate Cause (Final Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph\_sician/ Small Cell Lung Carcinoma Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): B To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician a page 2 should be detached for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Y Other (Specify) Hospice filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npletely 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) (15 May 14, 2012 D 37142 O. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)
G. Coleman, M.D., 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) State MAY 15 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Month Day 2012 Year 14, Rebecca Leprince Mary 4:30 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wilson Healthcare at Asbury Village Gaithersburg Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | July 13, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F 578-16-1874 95 Virginia Director Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Edgewater 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 3510 Dental Court 21037 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify. Completed 3 Midowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry المالية المالية. Tal Hygiene, المالية المالية. All My (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beautician/Owner Beauty Shop 2 should be filed with h and Mental Hygien 7 is marked other tl event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Charles Newman Amick Geneva McClung other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert Cranston/Nephew 3510 Dental Court, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 🗓 Removal from State May 2012 Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Louisa, VA 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Months Immediate Cause (Final lacture to Threw Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Pregnant at time of death Day Year 2 1 No 9 Unknown g Unknown Division of Vital Records, P.O. ed by t detach signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed? Yes 2 No certificate ha irector, page 2 pathypuc carcinoms 2 No 1 Yes 25. as case referre o medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi

completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number Id. Robert Biselel nay 14, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ Dussell Justice 14. ROBERT BIRSCHBACH, MLD. Carthusburg Red.

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 ANGELA CAPONE LINTON 6:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death QUEEN ANNE'S HOSPICE CENTER CENTREVILLE QUEEN ANNE'S Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 214-38-7478 1 🗆 M 2 🗶 F 72 FEB. 29, 1940 **NEW JERSEY** Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😿 No MD QUEEN ANNE'S QUEENSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 112 MAINBRACE DRIVE 21658 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER'S AIDE 12 EDUCATION permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES CAPONE FLORENCE MEYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LLOYD E. LINTON / HUSBAND 112 MAINBRACE DRIVE, QUEENSTOWN, MD 21658 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER MAY 4, STEVENSVILLE, MD 2012 Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ FA. TO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner / Lherry 1009 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) least Examine Due to (or as a consequence of): : burial-t Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy fo in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death Year 1 Yes 2 No detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? HOSPICE CENTER 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United The Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY

State

31. Date filed (Month, Day, Year)

MAY

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph W. Louis Month 04/29/2012 8:00 avm Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HCR Manor Care Bethesda Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 03/08/1922 Min 577-94-9796 **Director** 90 Haiti Usual Residence of Decedent shov 10a. State Count ms 23a or 28a-f sho must be notified at the Maryland 10c. City. Town or Location 10d. Inside City Limits Director District of 1x Yes 2 ☐ No DC Washington, DC Columbia 10e. Street and Number 10g. Citizen of What Country? Funeral 1630 Irving St., 20010 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iter Examiner 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black "natural" Completed 3 Widowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Self-employed 7th Self-employed other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) item 27 is marked မ Dibani Louis LaMercie Thimonthe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 13207 Arctic Ave., Rockville, MD 20853 Jean Louis - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 🔀 Cremation 3 🗌 Removal from State Chesapeake 5/14/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility W.H. Bacon Funeral Home Wandac Bacon CC0361 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Artherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): Iding priyation. Hypertension Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Chronic renal failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate Failure to thrive 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo To the Hospital or Attending Physician: 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural work? 5 Pending after death. Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after

To the Funeral Directory

Completely filled in by determined Medical 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examples. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D19609

Registrar

10810 Darnestown Rd. Gaithersburg, MD 20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Tuli

MAY 1 0 2012

31. Date filed (Month, Day, Year)

Physiciar Medica Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	Please Type or Print in Black In	ndelible Ink. Ensure A	III Copies Are Leg	gible.
	For State of Maryland / Depart	artment of Health and N	lental Hygiene	
	State Registrar Cer	tificate of Death	Reg. No. 2 (	12 17026
ı/	1. Decedent's Name (First, Middle, Last)  Henry Benjamin LEV	INSON	2. Date of Death May 9, 2012	Year 2:22 Å M
r	4a. Facility Name (if not institution, give street and number) 8100 Connecticut Avenue #1006	4b. City, Town, or Location of Death Chevy Chase	4c. County Mor	of Death ntgomery
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign
_	Usual Residence of Decedent		Jan., 30, 4925	Inphois
irecto	10a. State 10b. County 10c. City, Town or Loc  Maryland Montgomery Chevy (			10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
Funeral Director	10e. Street and Number 8100 Connecticut Avenue #1006	10f. Zip Code 20815	10g. Citizen of United	What Country? 1 States
ed by Fur	I 1   Never Married 2   X Married I 1   X Voc 2   I No I	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto Yes 2 X No Specify:	cify Yes or No- Rican, etc.) 14. Rac Blac Specify	ce - American Indian, ck, White, etc. White :
Completed by	(Specify only highest grade completed) (Give k	lent's Usual Occupation kind of work done during most of work O NOT use retired)	ng	i ture
To Be	17. Father's Name (First, Middle, Last)  Benjamin Levinson		e (First, Middle, Maiden Surnam DS enberg	е)
	19a. Informant's Name/Relationship (Type, Print) Richard Levinson, Son  19b. Mailin 3803	g Address (Street and Number or Rura Montrose Driveway	Route Number, City or Town, S Chevy Chase,	<sup>St</sup> MD <sup>Zip</sup> <b>2</b> 0815
	20a. Method of Disposition  1  Burial 2  Communition 3  Removal from State 4  Donation 5  Other (Specify)	sition (Name of natory or other place) tan Crematory 05/	Date 20c. Location Alexand	- City or Town, State dria, VA
		orchinsky Hebrew 54 Carroll St., N		DC 20012
ler	23a. Part 1 Entit the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	er the mode of dying, such as cardiac of	r respiratory arrest,	Approximate Interval Between Onset and Death Smonths
edical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.			
Pnysician/Medic		Ectopic pregnancy Other (specify)		ate of delivery onth Day Year
	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco use cont	tribute to the cause of death?
Completed by			autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
g	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check	only one)	
e: 10	27. Manner of Death 28a. Date of injury 28b. Time of	It 3 🗆 DOA   4 🗆 Nursing Ho	me 5 Residence 6 Oth	
car	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 \( \text{Yes}  2 \text{ No} \)	Edd. Describe flow injury occurr	ou .
Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street and Numb City or Town, State)	er or Rural Route Number,
Medical Certificate;	29a. Certifier (Check conly one)  1	igation, in my opinion, death occurred at	the time, date and place, and du	e to the cause(s) and manner stated.
	29b. Signature and title of certifier	29c. License number  MD - DO0661		d (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint BRAZIEG Ry WAT	eins, MD. 1	14
e r	31. Date filed (Month, Day, Year)  MAY 1 0 2012  32. Registrar's Signature  A gard	3 1 3 4 - 1	~ 0.0 8	

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 5, 2012 4:15 ам Nam Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 578-94-4063 57 Director 1 M 2 F March 19, Hong Kong Usual Residence of Deceder al Hygiene. Lother than "natural", or items 23a or 28a-f shot vent, the Medical Examiner must be notified at 10a, State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 11106 Amherst Avenue 20902 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married <u>ک</u> Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Server Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Fisher is marked of မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. Ling Kong Cheung Kwai Ying Wong traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ying Chiu Lee/Husband 11106 Amherst Avenue, Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 11, 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2012 Alexandria, VA 21. Signatury of Funeral Service Licensee Francis J. Collins Funeral Home Inc. University Blvd. W. Silver Spring. MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breast Cancer with Metastases disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying equentially list conditions, Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Por Maria Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 🖾 No Day Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Division of Vital Records, P.O. á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 \(\sum \) Yes 2 \(\overline{\text{X}}\) No within 24 hours after death.

To the Funeral Director After this certificate I 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 1 Yes 2 🔯 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Cify or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D37142 May 5, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
G. Coleman, MD 1355 Piccard Drive, #100, Rockville, MD 20850

Registrar

State

31. Date filed (Month, Day, Year)

MAY 1 0 2012

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ra Lewis Le	ee	1- For State Registrar	tate of Maryla		artment of <i>rtificate of</i>		Mental Hy	/giene Reg	201	2 170
Physicia cal Exami		Decedent's Name (First, Middle)  ED		EWIS	LEE			2. Date of Death	Day Year	3. Time of Death 1716 hrs
		4a. Facility Name (if not instituti 4151 Kennilwoth Ave		mber)	4	b. City, Town, or Lo Bladensburg	ocation of Death		4c. County of Dear	
Funeral Director		5. Social Security Number UNK .	6. Sex	7. Age (In yrs. I	last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		(MM/DD/YYYY) 9. Bi Fore:	
r any		Usual Residence of Decedent 10a. State 10b. County			, Town or Location	on			., -, -, -,	10d. Inside City Limits
Maryland 28a-f show d at once.	Director	MD. PRINC  10e. Street and Number	E GEORGE'S	S	R	RIVERDALE 10f. Zip Code		100	. Citizen of What Cou	1 Yes 2 No
th the Man		6011 LONGF				2073			U.S.A.	
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f thoringury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		larried 12. Was Dece Armed Fo 1 Yes vorced If Yes, Give Year	2 X No	lf Y∈	s Decedent of Hispa es, specify Cuban, M	Mexican, Puerto I		White, etc.	nican Indian, Black,
natural"	ed by	3 Widowed 4 Div 15. Decedent's Education (Spe	or Dates:		16a. Decedent	Yes 2 X No sets Usual Occupation ost of working life. D	n (Give kind of w	ork done 1	Specify: B	LACK /Industry
d 2 should be filed within 72 h ith and Mental Hygiene. n 27 is marked other than "r numatic event, the Medical E	Completed	Elementary/Secondary (0-12)		-4 or 5+)		IANDYMAN	ONOT use recit	ed)	SELF EMP	LOYED
ntal Hygi ked oth	Be Co	17. Father's Name (First, Middle VERT		LEE		18.		(First, Middle, Ma CRALDINE	iden Surname) BUSH	
should t and Mer 7 is mar natic eve	٩	19a. Informant's Name/Relations	ship (Type, Print)				and Number or Ri	ural Route Numbe	er, City or Town, State	e Zip Code)
l and 2 Health fitem 2 er traum		20a. Method of Disposition	/BROTHER		I I I SI Place of Disposite crematory or other	tion (Name of ceme	NEW C		DE. 19720 Poc. Location - City or	Town, State
ment of		4 Donation 5 Other S	Decify:	iii Glato	IAMBERS	CREMATORY		21-2012	RIVERDAL	
Depar Impo		21. Signature of Funeral Service	icensee Imbels	(I) MOO	)091 58	ame and Address of IAMBERS FU 101 CLEVEI	Facility JNERAL H LAND AVE	IOME & CI	REMATORIUM RDALE, MD.	P.A. 20737
dedical- aminer	Examiner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of negaly consequence of	f):					Between Onset and Death
nysician and	Medical	X UNPENDED		3a-b,27	,per me	,g928 6−2	6-12 sm			
the attending physed for use as the bi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Uni	1 Live bir	ant at time of dea	2 Feta	al death 3 a	Ectopic pregnan	су	23d. Date of deliver Month	y Day Year
det	Completed by P	Part II. Other significant condit	ons contributing to	death but not re	esulting in the un	iderlying cause give	en in Part I.	1 Yes  24a. Was an autopsy	24b. Were au	the cause of death?  pably 4 Unknown  topsy findings available completion of cause of
		25. Was case referred to medica				26 Place of	Death (Check or	performe	d? death? No 1 ✔ Ye	es 2 No
er this	n: To Be	examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 In In 28a. Date o		ER/Outpatient 28b. Time of Inj	3 ☐ DOA Oth	ner Nursing		sidence 6 🗹 Other	r. Scene
within 24 hours after death.  To the Funeral Director: completely filled in by the f	Certification:	3 Suicide 6 Coul	ling stigation		ome, farm, street,	1 Yes	2 No ling, etc. 2	28f. Location (Stre or Town, State		ıral Route Number, City
	Medical (		nysician: To the best miner: On the basis of	examination an						
4 % <b>4</b> 8	We	29b. Signature and title of certifie Pumul Juish	and manner sta	ateu.		29c. License no O.C.M.I		1.	9d. Date signed <i>(Moi</i>	nth, Day, Year)
Sta		30. Name and address of person Pamela E. Southall, M 31. Date filed (Month, Day, Year)	D Assistant M	ledical Exan	miner 900		Street, Baltim	ore, MD 212	23	
Sta Registr		MAY 2	2012 2	when s	3. par	Ke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 101 2 201 2 3 Joann Mess 7:48 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-74-3143 (Month, Day, Year) 53 Hours **Director** 1 M 2 X F 09/07/1958 Washington DC Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Anne Arundel Shady Side 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1238 Steamboat Road 20764 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc ģ 1 Never Married 2 X Married should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No White 3 🗌 Widowed 4 🗀 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use ctired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked ည Joseph R. Schaeffer Rosemary Carroll and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Keith Mess Spouse 1238 Steamboat Road Shady Side, MD 20764 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. . Page 1 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 05/08/2012 Glen Burnie, MD 21. Signature of Fungral Service Lig 2. Name and Address of Facility 22. Name and Address of Facility
Hardesty Funeral Home P.A.Annapolis, MD 21401 Vat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ ance Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease of Injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe To the Hospital or Attending Physician: The Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 . Impatient 2 ER/Outpatient 3 DOA 27. Manne eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes Investigation 6 Could not be the Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month, Day, State MAY 1 1 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician/ MILTON RICHARD MYERS, SR. Medical MAY 10, 7:50 A M 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11630 POSSUM HOLLOW ROAD WORTON KENT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Min Director 212-40-0212 08/14/1938 MARYLAND Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD KENT WORTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11630 POSSUM HOLLOW ROAD 21678 UNITED STATES 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th 12 **FARMER** AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ MILTON CARL MYERS ELMA USILTON 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MYERS / WIFE 11630 POSSUM HOLLOW ROAD WORTON, MARYLAND 21678 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) JAMES CEMETERY 05/14/2012 WORTON, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Inset and Death Ph sician/ etastatik disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed 25 and tran resulting in death) Last Due to (or as a consequence of). physician a s the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Month 2 No ed by the a 9 Unknown P.O. I signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate has autopsy perform Yes 2 after death.

Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Hospital ျှ 1 🗌 Yes Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? 2 🗆 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after
To the Funeral Dire
completed filled in b City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

ms State Registrar

C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0002

D 0021 737

29d. Date signed (Month, Day, Year)

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Phy	/siciar		1. Decedent's Name (First, Mic	idle, Last)						2. Date of De Month		ay Yea	r	ne of Death
ı	Medic	al .	Lauren 4a. Facility Name (if not institut	Dougla		M	ills	Town or Lo	cation of Death			2012 Year	3:	31 a <sup>M</sup>
Ex	amine	er	12904 Draper		and number)			ar Spi		1		Washing		
Fur	neral		5. Social Security Number	6. Sex	7. Age	(In yrs. last birthda	y) If Und	er 1 Year II	Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9 F	Birthplace (Sta	ate or Foreign
Dire	ctor	1	214-34-9773 Usual Residence of Deceder	1 <b>X</b> M	2 □ F <b>7</b> 4	Yrs	Months	Days I	Hours Min.	6/5/19	37	Ma	arylan	d
/land f show	d at	tot	10a. State 10b. Cou			10c. City, Town or	Location							de City Limits
Man)	otifie	Director		hington		Clear	Sprin							Yes 2 No
vith the 23a or	st be r		10e. Street and Number  12904 Draper	Road			10f. Z	p Code <b>2172</b> 2	2			itizen of What	Country?	
eath v	er mu	Funeral	11. Marital Status	12. W	/as Decedent Ev	ver in U.S. 1	3. Was Dece	dent of Hispa		pecify Yes or No		14. Race - Ar		n,
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The property of the trans and Mental Hygiene.	xamin	2	1 Never Married 2 XI 3 Widowed 4 Divor	Married 1	Yes 2 1 h Yes, Give ear or Dates.	No		-	Specify:	o riiodii, oto.,		Black, Wh Specify:	White	
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121: thin 72 ane. than '	Je Me	<u>E</u>	Elementary/Secondary (0-1		ollege (1-4 or 5-	life	. DO NOT us	e retired)	ng most or wor	run.g		m 1 . 4 .		
d 2 Hygie	ent, ti	a l	12 17. Father's Name (First, Midd	le, Last)			Super	visor	8. Mother's Nar	ne (First, Middle	, Maider	Trucki Surname)	ng	
rlan dental	tic ev	잍	Milton A. N	lills					Jean E	. Repp	ı			
Maryland 21215-0036 12 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", o	rauma		19a. Informant's Name/Relatio							ral Route Numb	_			
and 2 Health	other t	- 4	Tracy Gelwicks 20a. Method of Disposition			20b. Place of Di	sposition (Na	me of	Ave., n	agersto	_	ocation - City		ie
mol	ny or		1 Burial 2 Cremat 4 Donation 5 Oth	ion 3 🗌 Remo er <i>(Specify)</i>	oval from State	Rest Hav	rematory or en Cer		5/1	4/2012				
Baltimore, permit. Page 1 and Department of Hes Important: If item	any injury once.	Ī	21. Signature of Funeral Servi	se bicensee	nis	£n	22. Name a	nd Address o	of Facility <b>F</b>	lest Hav	en I	uneral	Chape	1
		+	23a. Part 1. Enter the disease			the death. Do not				Ave.,		rstown	Approx	imate
Physiciau Medical Examiner			shock, or heart failure. L Immediate Cause (Final disease or condition	ist only one cau	se on each line. PER	PIPHERA	V	95 CU	LAR	DISEA	SE		Onset	Between and Death
			resulting in death)	OFFILINGRAL VASCULAR DISEASE  Or as a consequence of:  TYPE 2 DIABETES								4		
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uted	g physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	5 .										
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Serti redin	use as		IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome of pregnancy 1			3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					d. Date of delivery Month Day Year	
Records, P.O. Box 68 The law requires that the death certi ate has been signed by the attendin	led for	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4										
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aw req	2 sho	Completed	CHRONIC KIDNEY DISE				ASE 24				autopsy prior to completion of cause of			
ital Reco	; page									perf 1 🗆 Yes	ormed?	death	? Yes 2 No	)
of Vital Physician:	irecto	m i	25. Was case referred to medi examiner?  1 ☐ Yes 2 ☑ No		26. Place of Death (Check only one)  Hospital: Other: Other:									
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Div To the Hospital or within 24 hours afte To the Funeral Dir	completely filled in by the funeral director,	Medical	29a. Certifier 1 Certif	ing Physician:	Physician: To the best of my knowledge, death or			ccurred at the time, date and place, and due to the			ne cause(s) and manner as stated. ate and place, and due to the cause(s) and manner stated.			
the Hi hin 24 the Fu	трІете	Mec	only one) 3 Certif	ing Nurse Pra		amination and/or in best of my knowled	ige, death oc	curred at the	time, date and p		the caus	se(s) and manne	r as stated.	
ر الاستار الاستان	8		29b. Signature and title of cer	ifier .	D.		29	b. License nu	12 F Z			ate signed ( <i>M</i> o.		7
المر	6	ł	30. Name and address of pers			eath (Item 23a) (Typ	e, Print)	33	trKi.	+ Dri	700			
3	' '		SAMUEL 31 Date filed (Month Day V	KA	-		<u>0:</u>	lliar	nspor	+ "	D	2179	5	
Re	Stat gistra	e Ir	31. Date filed (Month, Day, Yea	4 2012	32. registra	rs signatur	1000	The same of the sa						

	Please Type or Print		·								
	1 - State of Mary Registrar	land / Department of F Certificate of L		giene Reg. No. 2012 17032							
Physician/ Medical	1. Decedent's Name (First, Middle, Last)  Jerome Martin Ma	9 , 2012 Year 3. Time of Death 2337 M									
Examiner	4a. Facility Name (if not institution, give street and number) Shady Grove Adventist	4c. County of Death Montgomery									
Funeral Director	5. Social Security Number 6. Sex 1 1	vrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Bit Hours Min. 4 Months 2	9. Birthplace (State or Foreign PA <sup>untry)</sup>							
aryland a-f show fried at	Usual Residence of Decedent  10a. State MD 10b. County Montgomery 10c.	:. City, Town or Location  Rockvill	e	10d. Inside City Limits 1 🎽 Yes 2 □ No							
leath with the Maryland tems 23a or 28a-f sho er must be notified at Funeral Director	10e. Street and Number 5309 Trailway Drive	10f. Zip Code 208	53	0g. Citizen of What Country?							
, F.E	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.	n U.S. 13. Was Decedent of Hi If Yes, specify Cuba 1  Yes 2 XNo	ispanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.)  Specify:	14. Race - American Indian, Black, White, etc. Specify: White							
21215-0036 within 72 hours after giene. t, the Medical Exam.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	during most of working	16b. Kind of Business Industry							
d 212 led within Hygiene other the ent, the	Elementary/Seconday (0-12)  College (1-4 or 5+)  17. Father's Name (First, Middle, Last)	High Schoo	1 Principal	Education							
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Mar nd 2 shou ealth and m 27 is m ner traum	19a. Informant's Name/Relationship (Type, Print) Mary Marco/Wife		and Number or Rural Route Numb ay Drive Rock	tvirie, Ma <sup>z</sup> 20853							
Baltimore, permit. Page 1 and Department of Hea mportant: If item my injury or other proces.	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Ob. Place of Disposition (Name of cemetery, crematory or other place Unity Cemete:									
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h_sician/ Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faithre. List only one cause on each line.  Approximate Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Interval Betwoonset and Do not enter the mode of dying, such as cardiac or respiratory arrest,  Interval Betwoonset and Do not enter the mode of dying arrest,  Interval Betwoonset and Do not enter the mode of dying arrest,  Interval Betwoonset and Do not enter the mode of dying arrest,  Interval Betwoonset and Do not enter the mode of dying arrest,  Interval Betwoonset and Do not enter the mode of dying arrest,  Interval Betwoonset and Do not enter the mode of dying arrest,  Interval Betwoonset										
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Box 68 dea h certifi he a tending ed for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3 Ectopic pregnand	ey .	23d. Date of delivery Month Day Year							
G. # 50 5	Part II. Other significant conditions contributing to death but no	ot resulting in the underlying cause give		tobacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably 4 ❷ Unknown							
Division of Vital Records, all or Attending Physician: The law requires stater death.  In Director After this certificate has been signed in by the funeral director, page 2 should be a possible of the funeral director.			24a. Was auto perf	s an 24b. Were autopsy findings available prior to completion of cause of death?							
Vital Rec sician: The la certificate ha irector, page 2	25. Was case referred to medical examiner?  Hospital:  Other:										
rision of Vir r Attending Physis for death. rector. After this of by the funeral dire ertificate: To	27. Manner of Death 28a. Date of injury	28a. Date of injury (Month, Day, Year)  28b. Time of injury (Month, Day, Year)  28c. Injury at work?  28d. Describe how injury occurred									
Division of all or Attending P after death. I Director After the funeration by the funeration of the f	3 Suicide 6 Could not be	not be 290 Place of Injury. At home form street feature office									
Division To the Hospital or Attent within 24 hours after deat To the Funeral Director completed filled in by the Medical Certific	29a. Certifier (Check (Check only one)  1										
Note of the state	29b. Signature and title of certified MP	29c. License	number (0.5914	29d. Date signed (Month, Day, Year)  May 10 2012							
	30. Name and address of person who completed cause of death  Amy Schiffwan M	D 9901 A	redical rev	Her Drive mentonless							
State Registrar	31. Date filed (Month, Day, Year)  NAY 1 4 2012	ignature faul									

DHMH 17 Rev 06-2011

State

Registrar

John Deeken, MD

MAY 15

31. Date filed (Month, Day, Year,

3800 Reservoir Road, NW, Washington, DC 20007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 10, 2012 Elsie Musgrove 4:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1312 Nome Street Capital Heights Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Director** 577-34-6320 1 - M 2 X F 91 March 29, 1921 Usual Residence of Decedent Virginia -f show with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director a or 28a-f sh be notified a 1 Yes 2 No Maryland Prince George's Capital Heights 10e. Street and Number 10f. Zip Code r items 23a or iner must be r 10g. Citizen of What Country? 1312 Nome Street 20743 United States and 2 should be filed within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary 9th College (1-4 or 5+) alth and Mental Hygien 27 is marked other the r traumatic event, the Hotel Housekeeper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ James H. Witcher Vergie Pruitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Mary A. Evans - Daughter 1312 Nome Street Capital Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 4 Donation 5 Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home, T. M00560 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Unitedlying Due to (or as a consequence of) as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last <u>Hypertension</u> Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month
1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director, After this certificate h completely filled in by the funeral director, page death? performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\stackrel{\bullet}{\boxtimes}$  Residence 6  $\square$  Other (Specify, 1 Tes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

Adebowale Ajayi,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

6201 Greenbelt Road

29c. License number

MAY 1 5 2012

D45217

Suite M18

29d. Date signed (Month. Day, Year)

May 14, 2012

College Park, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Physician/ 8:04 A Tay Medical Location of Death

Burnie Facility Name (if not institution, give si 4b. City, Town Examiner House 8. Date of Birth **Funeral** Months Hours 1/2/12/27/1926 242-36-2610 85 1 □ M 2 💢 F Director North Carolina show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director 1 🗌 Yes 2 🗓 No Maryland Anne Arundel Millersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21108 1701 Baldwin Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 3 Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Fabric Shops Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edna Greer Theodore Augustus Hampton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1701 Baldwin Drive, Millersville, MD 21108 19a. Informant's Name/Relationship (Type, Print) Karl Kaifes/Executor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Cremation Service 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State 05/11/2012 Lenoir, N.C. 5 Other (Specify) 4 Donation <sup>22. Name and Address of Facility</sup> George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21 21. Signature Funeral Service Licenses d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Fater the disease, or complications that caus shock, or heart failure. List only one cause on each li Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration DHEUMONIA Physician/ Medical resulting in death) (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or injury The law requires that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) ding physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Pregnant at time of death 5 Other (specify) the a P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has After this certificate the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) å Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 
Yes 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural within 24 hours area control to the Funeral Director: After control the funeral by the fur 5 Pending 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ive, Glen Burnie, MO 21061 or thou State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHN THOMAS NICHOLSON 7:00 A M Medical MAY 9. 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 100 KENT MILL DRIVE KENT MILLINGTON Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 - F Hours 87 Yrs. 09/2071924 Director MARYLAND 216-18-8140 Usual Residence of Decedent 28a-f show 10a. State 10b. County or items 23a or 28a-r snorminer must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD **KENT** MILLINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 KENT MILL DRIVE 21651 UNITED STATES filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates.1943 - 46 Specify: WHITE 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PLUMBING/ELECTRIC PLUMBER/ELECTRICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ည Page 1 and 2 should be OLIVER CLINTON NICHOLSON MARGARET LESAGE and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 100 KENT MILL DRIVE MILLINGTON, MARYLAND 21651 CHRIS CLOUGH / DAUGHTER Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) STILL POND CEMETERY 05/15/2012 STILL POND, MARYLAND 21. Signature Funeral Service Licenses 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEÉR ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause a each line. the mode of dving, such at Immediate Cause (Final Onset and Death Priysician/ 10ma disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a co Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ō in the past 12 months? Month Pregnant at time of death signed by the a ☐ U*nkn*own P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has eral Director: After this certificate filled in by the funeral director, pag Yes 1 Tes Be 25. Was cast referred to medical 26. Place of Death (Check only one) Hospital Dand Hous Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Richard Eugene Norris 3:15 PM May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 118 Fairground Avenue Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 212-50-9147 **Director** 1 🛛 M 2 🗆 F 62 12/19/1949 Maryland er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MDWashington Hagerstown 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 Fairground Avenue 21740 U.S.A within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 alth and Mental Hygiene.
127 is marked other than it traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Katherine McClay permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Claude Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Norris/Wife 118 Fairground Avenue Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 5/12/12 Smithsburg Crematory Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel Signature of F ne al Service Licens 1601 Pennsylvania Ave Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. e mode of dy g, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a continuence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ned for Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 1 Yes 2 1 Yes 2 funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 000 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated npletely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address npleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month Pay

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21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mark 2-30M Elizabeth Nazelrod Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 220-28-3518 **Director** 1 M 2 F 9/10/1930 Maryland or 28a-f show notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Hagerstown 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 10901 Oak Forest Drive 21740 Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Blaine Eley Imogene Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mike Nazelrod Son 95 Traveller Rd., Falling Waters, WV 25419 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Lawn Mem. Park 5/12/2012 Hagerstown, Maryland Signature Fun Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Dullo (or as a cons Muence of) Physician/ disease or condition Medical resulting in death) **Examiner** sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: the law within 24 hours after death.

To the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2: autopsy performed? 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 440 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Hatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 006111 who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nettles Physician/ Mary May 2012 14 2:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery **Examiner** Chevy Chase Manor Care Nursing Home 5. Social Security Number 1921 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours April 1 91 243-30-2329 **Director** Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Md Montgomery Rockville 1X Yes 2 □ No ō 10e. Street and Number 10f. Zip Code 20850 10g. Citizen of What Country? 8 Monroe Street # 201 23a U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after 1 ☐ Yes 2X No Specify: Black Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should te filed within 72 Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mee Elementary/Seconday (0-12) College (1-4 or 5+) Domestician Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Marie McIver ပ္ Boyd Nettles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 8 Monroe Street # 201 Rockville Md 20850 Son Jesse R. Nettles 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State May Riverdale Park 4 Donation 5 Other (Specify) Riverdale 21. Signature of Funeral Service Licensee dc025 22. Name and Address of Facility McLaughlin Funeral Home 2518 PA Ave SE Washington DC 20020 23a. Part 1. Enter the diseas, or complications that caused the distribution at the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Failure to Thrive Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hypothyroidism and -transit that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical Dementia IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🕱 No Month Day Year Pregnant at time of death ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign I be The law requires 1 🗌 Yes 2 🗌 No 3 🗎 Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No Yes 2 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending • Hospital or Attendin 24 hours after death. • Funeral Director: Aff leted filled in by the fur 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D - 20274May 14 2012

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Vohra MD

Kirti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kirti Vohra MD 7710 Bradley Blvd

20817

Md

Bethesda

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death Physician/ Month. URAND 2012 ATRICIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Mandrin Inpatient Care Center Harwood Anne Arundel Social Security Number 8. Date of Birth (Month, Day, If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. Year) 61 **Director** 217-62-9951 1 🗆 M 2 🔀 F Yrs April 23,1951 Virginia 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 245 Tolstoy Lane 21146 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 10 Black, White, etc. 1 Never Married 2 XMarried Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Senior Housing Marketing Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Lawson Stella Holder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Ourand / Husband 245 Tolstoy Lane Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Hillcrest Memorial Gardens Page 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 11, May Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Septice Usensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park. MD 21146 P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final TERUS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or, physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 1 ☐ Yes 2... 9 ☐ Unknown Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 🗌 No 1 🗌 Yes Yes 2 🗌 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) MANDRIN examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Atural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1\_Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of Name and address of person who completed cause of death (Item 23a) (Type, Print) 441 DEFENSE HWG Registrar

			Please Type or Pring AMEND #25,27,28A-F State of Ma	it in B G932 arviand	lack In 10/24 1/ Depa	delible In	<b>k. Ens</b> Health	ure All and Me	Copie	s Are	e Legible	<b>).</b>
			1 - State Registrar	_		tificate of l				Reg. No	201	2 1704
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2	. Date of De			3. Time of Death
	Medi Examir	cal	Vilma M. Posson  4a. Facility Name (if not institution, give street and number)	_		4b. City, Town, o	. Looption		lay	09	2012	11:25 P <sup>M</sup>
	)	er	FutureCare Homewood	/h l=	465464	Baltin	more				c. County of De	
	Funeral Director			(In yrs. last <b>56</b>	Yrs.	Months Days	If Under Hours	Min.	Date of Bir (Month, Da	ay, Year)	0	irthplace (State or Foreign ountry)
	d t tow	L	Usual Residence of Decedent  10a. State 10b. County	10- 02-				l N	lov. 3	0,19	055 Cos	sta Rica
	th the Maryland 3a or 28a-f show t be notified at	Funeral Director	MD	-	altimo					-		10d. Inside City Limits 1 XYes 2 No
	vith the 23a or st be r	ralD	10e. Street and Number  2700 N. Charles Street			10f. Zip Code	210			10g. Ci	tizen of What C	country?
	death with items 23	-une	11. Marital Status 12. Was Decedent Ev	er in U.S.	13. V		218 ispanic Orio	gin? (Specify	Yes or No-		USA 14. Race - Am	erican Indian
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☒ Married I ☐ Yes 2 ☒ N 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	lo		Vas Decedent of H Yes, specify Cuba X Yes 2 No					Black, Whi	
15-	72 ho un "nai Medici	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occup ind of work done ( ) NOT use retired)	during most	of working		16b. k	(ind of Business	s/Industry
	within giene. er tha t, the I	CO	Elementary/Secondary (0-12) College (1-4 or 5+	)		lthcare		•			Home	
Maryland	nould be filed with and Mental Hygien s marked other thumatic event, the	To Be	17. Father's Name (First, Middle, Last)  Carlos	υ	ınk			er's Name (F				
N Z	ould b nd Mer mark matic		19a. Informant's Name/Relationship (Type, Print)		10b Mailin	g Address (Street		abeth		_		
	id 2 sho raith an n 27 is er trau		Laura Fritts / Niece	- 1		Freelan						ip Code)
ore	le 1 and t of Heal If item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	cem	ce of Dispos	sition (Name of atory or other place	e)	Mav Date	١.	20c. L	ocation - City o	
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signarum of Fuller (Spervice, Licebytee	Metr		matory,	INC	- 20	12		ltimore	·
Ba	Depar Impo any ir		K place 2		Ba   49	Name and Address rranco & 5 Ritchi	ss of Facility Sons e Hwy	P.A.	Seve	erna erna	Park F	uneral Home MD 21146
	-		23a. Part 1 Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line. Immediate Cause (Final	he death. [	Do not enter	the mode of dyin	g, such as o	cardiac or re	spiratory an	rest,		Approximate Interval Between
	Physician/ Medical		disease or condition resulting in death)  a. Due to (or as a condition)	Consequen	chei	phalo p	outh	1			1- /	Onset and Death
	Examiner	_	Sequentially list conditions, b.	mat	my	Faulm		^	11	11	DICAL EXAMINER	3 years
	ed sit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	A- e 0 a	ice oi):			I WILL	N APPROVE	D BY ME	010140-	3 year
	executed an and rial-transit		that initiated events resulting in death) Last  C. Due to (or as a d	consequen	ice of):			CERTFION			· .	
092		edical	d. Subohn	ne h	aena	time &	taltis	pert	Cran	mut	my	3 years cy
. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the br	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal de	eath 3 🗌	Ectopic pregnanc Other (specify)	у				23d. Date of de Month	elivery Day Year
P.O.	s that t gned b	by P	Part II. Other significant conditions contributing to death but	not resulting	ng in the un	derlying cause giv	en in Part I.		23e. Did to	bacco u	ise contribute to	the cause of death?
rds,	requires that the been signed be should be detailed				_			_ [	1 🗆 '	Yes 2	□ No 3 □ F	robably 4 L Unknown
of Vital Records,	The law rate has be page 2 s	Completed					_		24a. Was a autop		24b. Were au prior to death?	rtopsy findings available completion of cause of
al R	ician: The certificate rector, pag		25. Was case referred to medical			26. Pla	ace of Deatl	h (Check onl	1 Yes		1 ☐ Ye	s 2 No
Vit.	hysician: his certific al director,	유	examiner? 1 XYes 2 No Hospital: 1 □ Inpatien	t 2 🗆 ER	/Outpatient	Otho			· · · ·	lence 6	Other (Spec	cify)
n of	Jing After fune	sate:	27. Manner of Death  1  Natural 5  Pending 2  X Accident Investigation  28a. Date of injury (Month, Day, 1)  (Month, Day, 1)  MΔV 24 2	Year)	b. Time of injury	28c. Injury work	?	28d. SIJI	Describe h	ow injury	occurred	STRUCK BY A
Division	I or Attending safter death. Director. After d in by the fune	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury	- At home			Yes 2X	CAI	Location (S	treet and	d Number or Ru	ral Route Number.
Ω̈́			ROADWA	Y				ROA	City or Tow AD SEV	n, State) ERN	RTE 2 N A PARK,	ral Route Number, EAR MCKINSEY MD
	the Hos hin 24 ho the Fun npletely	Medical	29a. Certifier 1 Certifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of examiners only one) 3 Certifying Nurse Practitioner: To the basis of examiners only one)	mination an	nd/or investic	ation, in my opinio	<ul> <li>n. death ocr</li> </ul>	curred at the	time date a	nd place	and due to the	cause(s) and manner stated
	To the within To the comple		29b. Signature and title of certifier	W	0	29c. License	number				e signed (Mont	
			20 Name and address of a security	4 (IV )	1) (5)		3146	9		0	2 (11)	7
(1)	45	<	30. Name and address of person who completed cause of deal SHDAIIS A HASHMI MD	_		nt) FUTAN	T2 (	- 50	nite :	800	BAL	TIMORTMO
	Stat Registra		31. Date filed (Month, Day, Year) 32. Resistrar's NAY 1 4 2012									2/20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		partment of F ertificate of L			ne 2012	17042
	Physicia	in/	1. Decedent's Name (First, Middle, La Patricia A. Pat	•				2. Date of Death	Day 2012	3. Time of Death 6:39 A M
- Warden	Medio Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Death	l lay 05	4c. County of Death	0.39 A M
Sept.			527 Saltoun Ave			Odenton			Anne Arur	
	Funeral Director		5. Social Security Number 6. S 220-86-7415 Usual Residence of Decedent	Sex 7. Age	e (In yrs. last birthday 45 Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye) 10/14/19	ar) Coun	place (State or Foreign try) rland
	yland f shov ed at	tor	10a. State 10b. County		10c. City, Town or I		<del></del>		1	0d. Inside City Limits
	or 28a- notifi	Director	MD Anne A	rundel		Odenton 10f. Zip Code		100	. Citizen of What Cour	1 Yes XX No
	with the s 23a c	Funeral	527 Saltoun Ave.				21113	Tog	USA	idy.
Maryland 21215-0036	e filed within 72 hours after death with the Maryland that Hyglene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 243 If Yes, Give Year or Dates.		. Was Decedent of Hill Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
15-0	72 hou "natu ledica	Completed	15. Decedent's E (Specify only highest gi		(Giv	edent's Usual Occup e kind of work done o DO NOT use retired)	ation luring most of work	ing 16	b. Kind of Business/In	dustry
212	iled within 72 I Hygiene. other than '		Elementary/Secondary (0-12)  12	College (1-4 or 5	+)	Shipper			Internatio	nal
and	e filed ntal Hyg ed oth	ا م	17. Father's Name (First, Middle, Last)					e (First, Middle, Maid	den Surname)	
aryk	should be file h and Mental I 7 is marked o traumatic eve		Edgar M. Patch. J 19a. Informant's Name/Relationship		19b. Ma	iling Address (Street a		e Donohue  al Route Number, Cit	y or Town, State, Zip (	Code)
	nd 2 st ealth a m 27 is ner tra		Michael Patch	Brother					wn, MD 211	
Baltimore,	permit. Page 1 and 2 should be 1 Department of Health and Mente Important: If item 27 is marked any injury or other traumatic e		20a. Method of Disposition  1 ∑∑urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1	cosition (Name of ematory or other place Cemetery	e)		c. Location - City or To denton,MD	
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licen	see		22. Name and Addres	ss of Facility Har 7 Ave. An	desty Fun	eral Home, MD 2140I	P.A.
	Physician/ Medical Examiner	er	23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as a	the death. Do not e	nter the mode of dyin	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
092	death certificate be executed ne attending physician and ed for use as the burial-transit	edical Examiner	fa y, each g to an additionable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):					
	death certiffi he attending ied for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopuls? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d. Date of delive Month	ery Day Year
	quires that the en signed by tl ould be detach	þ	Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the	ne cause of death?
Division of Vital Records,	: The law requires cate has been sign ; page 2 should b	Completed			_			24a. Was an autopsy performed 1  Yes 2	prior to co death?	psy findings available mpletion of cause of 2   No
/ital	Physician: r this certific eral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	ent 2 🗆 ER/Outpat	Othe	ace of Death (Checi		e 6 Other (Specify	
of/	ng Phy fter this uneral o		27. Manner of Death  1 Natural 5 Pending	28a. Date of injui (Month, Day	y 28b. Time		/ at	28d. Describe how i		,
sion	uttendi death. stor: A y the fu	Certificate:	2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not b	De 29a Place of Inju	ry - At home, farm, s	M 1 🗆	Yes 2 No	29f Location /Stree	t and Number or Rural	Pouto Number
Divi	tal or A rs after al Direct ed in b		4 ☐ Homicide determined	building, etc		rect, lactory, office		City or Town, S		Houte Number,
	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check 2 Medical Exam	rsician: To the best of hiner: On the basis of ex rse Practitioner: To the	kamination and/or inv	estigation, in my opinio	n, death occurred a	t the time, date and p	lace, and due to the car	use(s) and manner stated.
	Vith Con Con		29b. Signature and title of certifier	Sauce	u	29c. License	number _ 2790	1 Z 29d.	Date signed (Month,	Day, Year)
	5 w		30 Name and address of person who Educul A. Saus	completed cause of de	eath (Item 23a) (Type	1 1 1/10	lica Ch	125.6	resust b.	Baltery 212
	Stat Registra		31. Date filed (Month, Day, Year)  MAY 1 1 2		r's Signature	hard				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4:15A. 2. Date of Death Annie McCorkle Pike Day 2012Year Physician/ Meteorth 10, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Renaissance Gardens at Riderwood Village Prince George's Silver Spring Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 □ M 2 □**x**F 90 Jan. 18, 1922 245-18-2603 North<sup>y)</sup>Carolina **Director** Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 🚈 No Marvland Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 3160 Gracefield Road, RC#1405 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. \$ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3X Widowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Annie Louise Dixon James C. McCorkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12488 E. Nuggett Court Highland, Maryland 20777 Patricia P. Ward -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Shepherd Memorial Park 5/16/2012 Hendersonville,North Carolina 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses One 10 Modern Bolfgwardt Funeral Home, PA LBa 0-4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final one week Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner eight years Advanced Dementia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of signed by the attending physician and deep be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension; Arteriosclerotic Cerebralvascular Disease 1 Tes 2 No 3 Probably 4 Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 24 N death? 2 X No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

20

31. Date filed (Month, Day, Year) MAY 1 4 2012

29b. Signature and title of certif

30. Name and address of person to Eileen Gemmell,



3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

15866

ed cause of death (Item 23a) (Type, Print) 3160 Gracefield Road Silver Spring, Maryland 20904

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clifton J. Price Jr. May 11, 2012 10:03 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 577-56-3905 1 X M 2 D F Director 69 Sept. 4, 1942 Washington, DC 3a or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 23a Funeral and Mental Hygiene.
and Mental Hygiene.
/ Is marked other than "natural", or items 23s 1217 Arcola Avenue 20902 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 □ No
If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 Never Married 2 Married Black, White, etc. þ 1 Tes 2 No Specify: 3 Widowed 4 Divorced black Completed Year or Dates VietNam 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dentist Dentistry Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton J. Price Sr. Alma B. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Billauer Price, Wife 1217 Arcola Avenue, Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation Tomber (Specify) Beth David Cemetery 05/13/12 Elmont, L.I., NY Sign Funeral \$ Forchinsky Mebrew Funeral Home 81254 Carroll St., NW, Washington, 20012 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Esophageal Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 1 Yes 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital
within 24 hours a
To the Funeral D 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) D 0063195 May 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814 Steven D. Wilks, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Sign State

Registrar

MAY 15 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pearl Ĺ. Purcell 2:52 P. M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bowie Health Center Prince Georges Bowie 8. Date of Birth
(Month, Day, Year)
Dec. 14,1921 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Hours Director 218-34-5333 1 □ M 2 😿 F 90 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Prince Georges Bowie 1 X Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 12618 Kornett Lane 20715 United States items 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner Armed Force o. þ 1 Never Married 2 Married Yes 2X No Maryland 21215-0036 within 72 hours after Specify: White 1 Yes 2 No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Bakery Sales Grocery Store 8 Be 17. Father's Name (First, Middle, Last) should be file. Ith and Mental h 18. Mother's Name (First, Middle, Malden Surname) William Albert Kisner Mary Lucinda Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other trau Patricia Reeley/Daughter 2707 Higbee Road Adelphi, MD 20783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mav<sup>Date</sup>4 1 XBurial 2 Cremation 3 Removal from State Union Cemetery Burtonsville,MD 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Lic 22. Name and Address of Facility Hysong Company /CC0367 2222 Wisconsin Avenue N.W. Washington, D.C. 20007 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardiopulmonary arrest Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Demetia Examine Due to (or as a consequence of). that the death certificate be executed sician and burial-tran Hypertension resulting in death) Last Due to (or as a consequence of) physician s the buria Physician/Medical Box 68760 as attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 Month Day Year Yes 2 🔀 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ pe 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has page 2 autopsy performed? Yes 2 XNo prior to completion of cause of death? Hospital or Attending Physician: The 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 XNo Be 26. Place of Death (Check only one) Hospital: Other: 은 1 X Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending after death. 1 Yes 2 No M filled in by the 1 Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29b. Signature and title of certifie. 29c. License numbe 29d. Date signed (Month, Day, Year) D0057400 20/2

Registrar

DHMH 17 Rev 06-2011

30. Name and ad

Α

ate filed (Month, Day, Year)

Thomas

MD

Mercantile Lane Largo, MD 20774

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1221

12-03802 Sampach Prak

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate of	of Death	Reg. No	).	
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)			Date of Death     Month Day	3	3. Time of Death 1249 hrs
Medical Examiner	Sampach Prak  4a. Facility Name (if not institution, give stree	et and number)	4b. City, Town, or Location of Deatl	May 18, 2012	c. County of Death	1249 1115
-	University Hospital		Baltimore			
Funeral Director	5. Social Security Number 6. Sex 1219-94-9632 1 M	7. Age (In yrs. last birthday) 2 F 42 Y	If Under 1 Year   If Under 24Hr:   Months   Days   Hours   Mir	_	Foreign	olace (State or try) Cambodia
v any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca			I .	0d. Inside City Limits
ryland a-f shm it once.	Maryland Freder  10e. Street and Number	ick	Frederick	10a Ci	tizen of What Countr	Yes 2 No
auth with the Maryland litems 23a nr 28a-f abn ast be notified at once meral Director	1818 Granby Way		21702	Unit	ed States of	America
		Armed Forces? If  Yes 2 X No	/as Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:		14. Race - America White, etc. Asia:	
ours aft	15. Decedent's Education (Specify only hig	tes: hest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of most of working life, DO NOT use ret		Kind of Business/Ind	lustry
5-0036 ed within 72 hour stygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	ollege (1-4 or 5+)	Employed Businessman		Retail	
21215-0036 Juid be filed within 72 hours a Mental Hygiene. marked other than "natura ic event, the Medical Exami TO Be Completed by	17. Father's Name (First, Middle, Last) Sambath Prak			e (First, Middle, Maider Chly Sunsreng		
MD 21 d 2 should the and Me a 27 is ma martic even managed or To	19a. Informant's Name/Relationship (Type, P Paula Prak / Wife		ng Address (Street and Number or Granby Way, Frederic			(ip Code)
Baltimore, MD 2' pernit. Pages I and 2 should Department of Health and Mc Important: If item 27 is ma injury or other traumatic e	20a. Method of Disposition  1 X Buriel 2 Cremation 3 Re 4 Donation 5 X Other Specify: En1	moval from State crematory or c	sition (Name of cemetery, other place)  Cemetery  Vet Cemetery	Date 2012 20c. 26, 2012 G	Location - City or To Frederick, Emantown,	own, State MD aryland
Balti permit. Departu Impurt injury i	21. Signature of Funeral Service Licensee  Mark Oellig Per DV	22. Ke	Name and Address of Facility eney & Basford P.A. I 6 East Church Street	Funeral Home, Frederick,	Maryland 21	701
Physician /Medical	23a. Part I. Enter the disease, or complication failure. List only one cause on each line	ns that caused the death. Do not enter	the mode of dying, such as cardiac o	or respiratory arrest, sh		Approximate Interval Between Onset and
Examiner		Iltiple Injuries word (or as a consequence of):	rith Complication	S		Death
ner	Sequentially list conditions, if any, leading to immediate Due to cause. Enter Underlying Cause	(or as a consequence of):	· · · · · ·			
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last  Due to	(or as a consequence of):				1
execu an and al - tra	d.  X UNPENDED  X AME	nded 20 a-c,21, per I 23a,27,28a-f pe	H,g927 5-30-12 S	M vt		
x 68760, h certificate be tending physici use as the buri	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregnancy Live birth 2 F	etal death 3 Ectopic pregna	23	d. Date of delivery  Month Day	· Year
). Box 687 the death certification by the attending teched for use as the Physician.	1 Yes 2 No 9 Unknown 9	Unknown	ther (Specify)			
P.C ss that gned le deta	Part II. Other significant conditions contri	buting to death but not resulting in the	underlying cause given in Part I.		use contribute to the	
Records, The law requires ficate has been sig , page 2 should be				24a. Was an autopsy performed?		osy findings available apletion of cause of
tal Reco	25. Was case referred to medical		26.Place of Death (Check	1 ✓ Yes 2 N	lo 1 Yes	2 No
Vital hysician hysician this certical director	examiner? 1 ✓ Yes 2 No	l: 1 🗹 Inpatient 2 🗌 ER/Outpatien	t 3 DOA Other Nursin	ng Home 5 Reside	ence 6 Other:	
ion of Vi tending Physi eath. tor: After this the funeral dir	1 Natural 5 Pending	ta. Date of Injury (Month, Day, Year) 28b. Time of 15-17-12 15:30	4 Vec 3 € No	28d. Describe how inj subject j		n his
Division of Vital Records,  To the Boppital or Attending Physician: The law require within 24 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should bedical Certification: To Be Completed	Suicide 6 Could not be	Be. Place of Injury - At home, farm, stree Specify) major roa	eet, factory, office building, etc.	moving ve 28f. Location (Street a or Town, State) Frederick	9300b1k L	Route Number City
Divis  To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifica	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the	the best of my knowledge, death occu- e basis of examination and/or investiga- nanner stated.		due to the cause(s) ar	nd manner as stated.	ause(s)
M S t S t	29b. Signature and title of certifier	annot stated.	29c. License number	A or	Date signed (Month	Day, Year)
	30. Name and address of person who comple	ted cause of death (Item 21a)	O.C.M.E.	May	y 21, 2012	
	Theodore M. King, Jr., MD.	Assistant Medical Examiner	900 W. Baltimore Street, B.	altimore, MD 212	223	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maynth 11:03A Donald Powell 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 701 Glenwood St. Apt 421 Annapolis Anne Arundel Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours 219-40-4052 **Director** 1**X** M 2 □ F 68 Yrs. Dec 29 1943 Maryland Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 ☐ Yes 2X No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Glenwood St. Apt 421 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or Black, White, etc. by 1 Never Married 2X Married 1 Yes If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Black Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11th Installer Carpet is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ William Powell Gladys Makell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Margo Offer(Cousin) 1782 Belle Dr. Annapolis, Md. 21401 Baltimore, 20a. Method of Disposition 20b. PBre of Pisopatilen (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Memorial Park 5-10-12 Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Mmame Racescof ScilitSons Mortuary, P.A. Lavy 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a consequate of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ led by the atten detached for u in the past 12 months? Day Year Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 155-1 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed?

1 Yes 2 No certificate I 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Division of 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director, After th Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 -Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -A-Phill

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month C u folo Physician/ ora 9:48 AM 2112 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Numbe 095-26-7165 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min Hours **Director** 1 M 2 XF 80 2/14/1932 New York 28a-f shov Id be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Queen Anne's Stevensville 1 Yes 2 No 10e. Street and Number ō 10g. Citizen of What Country? "natural", or items 23a Funeral 225 Batts Neck Road USA 21666 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ğ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary <u>Insurance</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Assunta Mirra Ernesto Rufolo permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christian Graham - Durable POA 225 Batts Neck Road, Stevensville, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗙 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore Crematory 5/11/2012 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Deat Physician/ neumoni weells disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequer resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Unknown Yes 2 No g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ farllingon's 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗆 Yes 2 🖼 မ 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) \*\*Department 2 - ER/Outpatient 3 - DOA Director: After this Division of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No Matural 5 Pending iniury Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person, who completed cause of death (Item 27a) (Type, Print) 445 MAY 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G928 6/14/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $M_{ay}^{Month} 8$ , Patricia Sue Roger  $201^{9}$ 2 Рм 3:14 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 2<sup>Specal</sup> Security Number 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Months Hours Min. Year <del>218</del>-78-3095 51 Yrs Director 1960 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medi al Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel MD 0denton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 783 Sunny Chapel Rd. 21113 **ŪSA** within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Race - American Indian. Black, White, etc. þ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Model. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Day Care Provider Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carroll Queen Frances Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 783 Sunny Chapel Rd., Paul Vincent Roger / Spouse Odenton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ื Cremation 3 🗌 Removal from State Metro Crematory 5/10/2012 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Fune al Service Licente Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Carcinoid Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 🔼 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending s after death. Accident 1 Yes 2 No Investigation M 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number D 46052 08/12

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poukway, annual of 140 21461

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 20<sup>°</sup>1°2 5:55 P <sup>M</sup> Ralph B. Ramsburg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glade Valley Center Walkersville Frederick 8. Date of Birth (Month, Day, Year)
May 24, 1926 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F **Director** 215-20-7514 85 MD Usual Residence of Decedent show 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No MD Frederick Thurmont 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6507 Fish Hatchery Rd. 21788 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 1944-46 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Lab Technician Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Norman Ramsburg Nellie Wachter ge 1 and 2 should b nt of Health and Mer :: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Harner/daughter 7966 Parkland Place, Frederick, MD 21701 Department of Hear Important: If it injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 05/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Utica Cemetery Utica, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the Js. use, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fair in. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiomyopouthy disease or condition resulting in death) Medical Examiner years Hypertensun Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to ras a consumence of Examine and transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed Yes 2 No 1 Yes 2 No Hospital or Attending Physician; **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 📉 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

neral Director: Aft
dilled in by the fur 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2. 3 🗆 Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 5-9-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rederick MO 21701 MO Zaidi Saeed 801 Toke House Ave 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

Barry	Duane	Randolph	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certif	ficate of Death		, <u></u>	Reg. No. 20	12 1705
Physici ledical Exam		Decedent's Name (First, Middle,Last)     Barry Duane Randolph				2. Date of Dea Month May 11, 2	ath Day Year	3. Time of Death 1033 hrs
The state of the s		Facility Name (if not institution, give street and number)     823 North Avondale Road		4b. City, Town, o	or Location of Dea		4c. County of Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (I 220-66-0757 1X M 2 F 54	In yrs. last	birthday) If Under 1 Ye Months Da				9. Birthplace (State or Foreign Country)MD
ow any		Usual Residence of Decedent		own or Location ndalk			5,133,	10d. Inside City Limits 1 XYes 2 No
with the Maryland us 23a or 28a-f show be notified at once.	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	
vith the N s 23a or e notifies	ral Dir	823 North Avondale Road  11. Marital Status 12 Was Decedent Ev	erin U.S	21222 13. Was Decedent of H	ispanic Origin? (		Jnited S	tates American Indian, Black,
MD 21215-0036 2 should be filed whin 72 hours after death with the Maryland h and Menal Hygiene. 23 to marked other than "natural", or items 23a or 28a-fah. matic event, the Medical Examiner must be notified at once	by Fune	1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 2 Married 3 Never Married 2 Married 2 Married 2 Married 2 Married 3 Never Ma	] No	If Yes, specify Cuba	n, Mexican, Puer		White, e	etc.
72 hours "natur I Exam		15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  College (1-4 or 5+)	eted) 16	Sa. Decedent's Usual Occupa during most of working life			16b. Kind of Busin	ness/Industry
5-0036 lled within 7 Hygiene. I other than	Completed	1 2 17. Father's Name (First, Middle, Last)		Security Of		o (First Model)		forcement
ID 21215-003 should be filed with and Mental Hygiene. 7 is marked other th	Be	Alvin S. Randolph			Jacqu	eline V	Maiden Surname) /erdella	_
MD 2' 12 should th and Mo 1.27 is ma	2	19a. Informant's Name/Relationship (Type, Print)  Jacqueline V. Knight/M		19b. Mailing Address (Stre 823North				
Baltimore, MD permit. Pages I and 2 sh Department of Health an Important: If item 27 is injury or other traumat		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 X Donation 5 Other Specify:	20b. Plac	ce of Disposition (Name of ce matory or other place) Gift Anaton	emetery,	Date	20c. Location - Ci Portla	ty or Town, State
Balti permit. Departm Importa injury o		21. Signature of Funeral Service Licensee	<u> </u>	22. Name and Addres 4522 Butler			ndro Funera	al Home
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do	o not enter the mode of dying	, such as cardiac	or respiratory arr	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atheroscler  Due to (or as a consequence)		Cardiovascula	ar Disea	se		Death
	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions)	ence of):					
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	ence of):					
760, cate be executed physician and the burial - transit	Medical	d.	t.II	,27,per me,g9	28 6-1-1	2 sm		_
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of 1 Live birth	of pregnance		Ectopic pregr	nancy	23d. Date of de Month	livery Day Year
att att	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time 9 Unknown	e of death	5 Other (Specify)				
n of Vital Records, P.O. Bing Physician: The law requires that the de After this certificate has been signed by the tuneral director, page 2 should be detached?		Part II. Other significant conditions contributing to death but Chronic Alcoholism	it not result	lting in the underlying cause	given in Part I.	l		e to the cause of death?  Probably 4  Unknown
ords, w require s been si	Completed by	onionic niconorism				24a. Was	an 24b. Wer	re autopsy findings available r to completion of cause of
Recc The lav ficate ha	Com					perform 1 Yes	rmed? deal	
Vital ysician this certi	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER		of Death (Check Other Murs		Residence 6 🗸	Other: Scene
		27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28		iry at Work? Yes 2 No	28d. Describe I	how injury occurred	
E 2 5 E	Certification:	4 Homicide determined (Specify)	- At home,	, farm, street, factory, office b	ouilding, etc.	28f. Location (S or Town, S		r Rural Route Number, City
To the Hos within 24 h To the Fun completely	edical	29a. Certifier 1 Certifying Physician: To the best of my kn one) 2 Medical Examiner: On the basis of examinar	owledge, o ation and/o	death occurred at the time, do or investigation, in my opinion	ate and place, an n, death occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
F 2 E 3	Me	29b. Signature and title of certifier		29c. Licens		\4.20°	29d. Date signed	
		30. Name and address of person who completed cause of death	1 (Item 23a	O.C.	IVI.E. UL	IME	May 12, 2012	
W-0				miner 900 W. Baltin	nore Street, E	Baltimore, MD	21223	
St Regist	~~~	31. Date filed (Morta, Day, Year) 32. Fegistrar's S	nynature	from the				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrate	vD#20lopeni	State of I FH,5/21/12;EM			artment of tificate of		and M	ental H		e 10. 2	012	17053
	Physicia	n/	1. Decedent's Nam	, ,	,						2. Date of I	Death		Year	3. Time of Death
	Medic	al		Ladel1	Robinson give street and number	-1		4b. City, Town,	ar Location	of Dooth	Month <b>May</b>				6:35p <sup>M</sup>
1	Examin	er			st Drive	/			r Spr:					y of Death g <b>omer</b> y	7
	Funeral		5. Social Security N			Age (In yrs. I	ast birthday) Yrs	If Under 1 Year Months Days	If Under	24 Hrs.	8. Date of I	Birth		9. Birthp	lace (State or Foreign
	Director		473-78-74 Usual Residence o		1 X M 2 □ F	50	Yrs.	Wortins Days	riours	IVIIII.	Feb.	[9,19	62	Minne	sota
	and show	or	10a. State	10b. County		10c. Cit	y, Town or Lo	cation						11	0d. Inside City Limits
	Maryla 28a-f	irect	MD	Montg	omery	Sil	ver Sp	ring							1 X Yes 2 □ No
	th the	alD	10e. Street and Nu		t Drive			10f. Zip Code 20904						What Coun	
	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status	ar ore	12. Was Deceder	nt Ever in U.S	S 13 \	Was Decedent of		igin? (Spec	ify Yes or N			State	
9	ter de	by F	1 Never Mar	ried 2 🔀 Marri	Armed Forces ed 1  Yes 2	3?		f Yes, specify Cub	oan, Mexicar	n, Puerto R	Rican, etc.)		Bla	ack, White, e	etc.
88	urs af tural" al Exa	ted	3 D Widowed		If Yes, Give Year or Dates			I□Yes 2XN		·:			Specif	y:Afric Ameri	
5	72 ho n "nat	nple		<del></del>	t grade completed)		(Give	dent's Usual Occu kind of work done O NOT use retired	during mos	at of workin	g	16b.	Kind of I	Business Inc	lustry
212	within giene. er tha		Elementary/Sec	conday (0-12)	College (1-4 c	or 5+)		or, Pla	,	ervice	28	NFI	. Pla	yers	Association
2	filed tal Hy d oth event	o Be	17. Father's Name		ast)						(First, Midd		n Surnan	ne)	
<u>₹</u>	uld be I Meni marke natic	으	John H.		7 7/1					•	binsc				
<u>a</u>	1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. If them 271 is marked at Hygiene "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		19a. Informant's N Nadine M		p(Type,Print) <b>son – Wif</b> ∈	9		ng Address (Stree Star Cre							
			20a. Method of Dis			20b. F	Place of Dispo	sition (Name of	200	Di	ate	20c.	Location	- City or To	wn, State
Ĕ	Page 1 ment of ant; If it ury or o		1 LXBurial 2 4 ☐ Donation	☐ Cremation 5 ☐ Other (S)	3 X Removal from State oecify)	te Eln	nhurst	sition (Name of natory or other pla Cemeter	y unk	05/19	9/2012	St.	Pau	11, MN	
3alt	permit. Page Department of Important; If any injury or once,		21. Signature of Fu	nerel Service Li	censee		22	. Name and Addr	ess of Facilit	ty McGi	uire 1	uner	al 8	Servic	e, Inc.
	<u> </u>	- 12	23a Part 1 Enter	the disease or	complications that cause	ed the deat		+00 Geor					, D(	2001	
	Physician/			art failure. List or	nly one cause on each I	ine.			ing, such as	cardiac of	respiratory	arrest,			Approximate Interval Between Onset and Death
	Medical		disease or conditi resulting in death)	on	a. Acute Due to (or a	Kena as a consequ	Failu uence of):	ire							Days
	Examiner	_	Sequentially list or	onditions	Hypero										Days
_	D # D	Examiner	Sequentially list or if any, leading to in	erlying	(C)	s a consequ		Myeloma							
	ecute and Il-trans	Exar	Cause (Disease or that initiated even resulting in death)	ts	C	s a consequ		riyeroma							Years
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	certificate inding phy use as the	Med	IF FEMALE:												
9 X	th cer ttendii or use	ian/	23b. Was deceden in the past 12			h 2 🗌 Feta	al death 3	Ectopic pregna	псу					ate of delive	ry Day Year
Box	g e g	Physician/Me	1 ☐ Yes 2 9 ☐ Unknown	□ No	4 ☐ Pregnan 9 ☐ Unknow		death 5∟	Other (specify)				-	141	Onti	Day real
0.	law requires that the des nas been signed by the s s 2 should be detached	by Pr	Part II. Other signi	ficant condition	ns contributing to death	but not res	sulting in the u	nderlying cause (	jiven in Part	1.	23e. Die	d tobacco	use cor	tribute to the	e cause of death?
ds,	quires en sign										1 [	Yes	2 🗓 No	3 🗌 Prob	ably 4 🗌 Unknown
Division of Vital Records,	aw rec as bee 2 sho	Completed									24a. Wa	topsy		prior to con	sy findings available inpletion of cause of
æ	The ate h										1 🗌 Ye	rformed? s 2 X	No	death?	2 🗆 No
<u>ta</u>	sician: The law I	Be c	25. Was case reference examiner?  1  Yes 2	red to medical	Hospital:			lot	Place of Dea	,					
o   	g Physer this eral di	e: To	27. Manner of Deat		28a. Date of in	njury	ER/Outpatier 28b. Time of	28c. Inju	4 ∟ Ni iry at		ne 5 🕰 Re 8d. Describ			ner <i>(Specify)</i> rred	<del></del>
O	ending eath. or; Afte he fun	ficat	1 X Natural 2 Accident	5 Pending Investig	ation	Day, Year)	injury		rk? ☐ Yes 2 ☐	] No					
VISI	or Atte	Certificate:	3 Suicide 4 Homicide	6 Could n determin	28e. Place of I	njury - At ho etc. (Specif)		eet, factory, office		2		(Street a		ber or Rural .	Route Number,
ā	To the Hospital or Attending Physiciam: within 24 hours after death To the Funeral Director; After this certification pleted filled in by the funeral director.		29a. Certifier	Certifying	Physician: To the best	of my know	ledge death	occured at the tim	e date and	place and	I due to the	cause(s)	and man	ner as stated	4
	ne Hos n 24 h ee Fun oleted	Medical	(Check	2 Medical Ex		f examination	n and/or invest	tigation, in my opir	ion, death o	ccurred at t	he time, dat	e and plac	ce, and d	ue to the cau	se(s) and manner stated.
	Vithi Vithi Comi		29b. Signature and	title of certifier			-	29c. Licen MD328	se number			29d. D	ate sign	ed (Month, E	Day, Year)
	25		<b>P</b> (	w	fuce				J-1			Lie.	, 10	. 2012	
					tho completed cause of the completed cause of the completed cause of the complete cause of the cause of t				25 Che	evy C	hase.	MD			
	Stat	e													
	Registra	ır	W/	Y 14 2	012 . Regis	U 19	. 19								

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State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Herbert Rubinstein May 2:17 am 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5450 Whitley Park Terrace. Montgomery #210 Bethesda Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 578-36-4798 Director 1 X M 2 🗆 F 81 08/02/1930 Washington, DC 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5450 Whitley Park Terrace, #210 20814 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 2 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural" Completed White. Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Retail snould be file th and Mental Hy 7 is mart 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham David Rubinstein Esther Berlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 5450 Whitley Park Terrace, #210. Bethesda, MD 20814 Marilyn Rubinstein - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 05/15/2012 Judean Mem. Gardens Olney, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death

9 Years Immediate Cause (Final Pnysician/ Metastatic Melanoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 nding physiuse as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Year Dav Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 Yes 2 X No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 💢 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After t 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Investigation 1 Yes 2 No 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated carringing. Number Proceedings of the cause of an investigation of the cause of the (Check 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D0061083 May 14, 2012 MD address of person no completed cause of death (Item 23a) (Type, Print) Paul Mookencherry Thambi, M.D., 9707 Medical Center Drive. #300. Rockville. MD 20850 1. Date filed (Month, Day, Year) 2. Registrar's Sign ture

Registrar

MAY 1 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Kankin Wintield 3 M 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sande Brooke Grove Assisted Living-Woods Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Months Days Hours (Month, Day, 09/02) Director 577-40-4707 Idaho Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Brookeville Maruland Montaomeru 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19430 James Creek Court 20833 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 \( \subseteq \text{No } 1942 - \) Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Divorced Completed 1946 Caucasian Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. American Institutes life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Architecture 5+ Lawyer Be 17, Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ Winfred Fuller Hugh Rankin other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 19430 James Creek Court, Brookeville, Maryland20833 Paul Winfield Rankin - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory: 05/17/2012 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation MOICEL Mae Center, 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ concer with metastases prostate disease or condition resulting in death) 1ears Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriahtransit ending physician and use as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) Hospital: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1. Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Grace Brocke Huffman, H.D. 18100 Slave Stade School Road Soud

State

Registrar

31. Date filed (Month, Day, Year)

MAY 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death May 14, 2012 Physician/ 9:05 A Marvin RABACH Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Hebrew Home of Greater Washington Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X**□ M 2 □ F Months Days Hours Jun. 3 , Yel 1930 New York 81 093-22-8925 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 6121 Montrose Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 Never Married 2 👿 Married 1 ☐ Yes If Yes, Give Completed by 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. white Specify: 3 Divorced Year or Dates ntal Hygiene. ted other than "natura c event, the Medical E 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If iten 27 is marked other the any injury or other traumatic event; the Ionce. **Publisher** Magazine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Aaron Rabach Lena Shaer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4517 - 20th Place, N., Arlington, VA Howard Rabach, Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 05/16/12 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance Memorial Park Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Forechirsky Hebrew Funeral Home S en e of Funeral Service License 254 Carroll St., NW, Washington, DC 20012 23a. Par 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ lung Cance disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Ilnjury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the bu Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No ξ Pregnant at time of death ned by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific.

Completed filled in by the funeral director, Division of Vital Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 5-14-2012 Doo6 4871 mina farle

Registrar DHMH 17 Rev 7/2009 6121

Montrose Rd

Rockville MO

20857

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

Fazli

MAY 1 5 2012

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland				lental Hyg	giene	
			1 - State Registrar		Cer	tificate of Dea	ath		Reg. No.	3 17057
	Physicia	ın/	Decedent's Name (First, Middle, Last)	3. D				2. Date of Dear May 3,		3. Time of Death
	Medic		Francisca Cuet  4a. Facility Name (if not institution, give st	o de Ramirez	•	4b. City, Town, or Loc		May 3,	2012 Year	11:20AM
-	Examin	er	9802 Snowden Ro	•		Laure	_		4c. County of De	Georges
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year If I	Under 24 Hrs.	8. Date of Birth	1 g. B	irthplace (State or Foreign
Ш	Director		5//-90-430/	M 2 X F 88	Yrs.	Months Days Ho	ours Min.	Sept. 2	Year) 1923 F	ountryDominicar Republic
	nd how at	<u>_</u>	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits
	anylar la-fs ified	ect	MD PG		ırel					1 🔀 Yes 2 □ No
	or 28	ij	10e. Street and Number	But	22-02	10f. Zip Code		1	10g. Citizen of What C	Country?
	s 23a nust b	<b>Funeral Director</b>	9802 Snowden Ro	ad		20708	8		United :	States
	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at			2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hispan Yes, specify Cuban, M	nic Origin? (Spec lexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give	1.	XIYes 2□No Sp	pecify:	nican	Specify:	·
21215-0036	hours natura ical E	Completed	15. Decedent's Edu		6a. Deced	ent's Usual Occupation		ublic	16b. Kind of Busines	oanish
215	in 72 e. nan "r	ртр	(Specify only highest grade Elementary/Seconday (0-12)	e completed)  College (1-4 or 5+)	(Give k	ind of work done during NOT use retired)		ng .	TOD. TAILE OF BUSINESS	s industry
21	ygiene. her tha	Be Co	2			Maid			Priv	ate
Maryland	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho marked other than "natural", ar items 22a or 28a-f sho marke event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
Ž	2 should be file th and Mental I 27 is marked o traumatic eve	ľ	Audelino Cueto  19a. Informant's Name/Relationship (Type	e Printi SON .	10h M-11-				Rosario	F 0 (1)
		1	Leonidas A. Ram	5, 1 11119	980	g Address (Street and N 2 Snowder rel MD-		Houte Number,	City or Town, State, 2	up Code)
ore,	ge 1 and 2 It of Healt If item 2 or other		20a. Method of Disposition			sition (Name of atory or other place)	20.708	ate	20c. Location - City of	or Town, State
<u>E</u>	mit. Page 1 partment of portant: If it injury or or	ij	1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	cirioval nom otate		Mem. Park	5/12	2/12	Landover	, MD
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Licenses	towned		Name and Address of 10 Silver			& Edwards	F.H. MD.20746
_	22200		23a, Part 1. Enter the disease, or complic	cations that caused the death. D						
	nysician/	V	shock, or heart failure. List only one Immediate Cause (Final	caus each line.	to	and mode of dying, od	ion do odi dide oi	roopilatory arro	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate Interval Between Onset and Death
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-	Examiner	_	Sequentially list conditions, b.	Hyperter	1511	m/typ	Perlip	1 der	nia	
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due t / (vr as a consequence	ce of):	, 11	31	1		
	cate be executed physician and the burial-transit	Еха	that initiated events c. resulting in death) Last	Due to (or as a consequence	ce of):					
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876	tificate ng phy as th	Med	IF FEMALE:							
Box 687	th cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy 1 🔲 Live Birth 2 🗀 Fetal de					23d. Date of de	
Bo	hat the death certific ed by the attending I detached for use as	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of deat 9 ☐ Unknown	h 5 ∐	Other (specify)			Month	Day Year
P.O.	The law requires that the death certific are has theen signed by the attending page 2 should be detached for use as	by Ph	Part II. Other significant conditions cont	tributing to death but not resulting	ng in the ur	iderlying cause given in	Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
S,	puires en sign uld be							1 □ Ye	es 2 🛮 No 3 🗆 I	Probably 4 🗆 Unknown
Sor	w equire as t een si 2 should I	plet						24a. Was ar		utopsy findings available completion of cause of
Rec	Tielaw aehasi pege 2 s	Completed						autops perform	med2 death?	
ta	sician: T certifica rector, p	Be	25. Was case referred to medical examiner?	ospital:			of Death (Check	only one)		
Ž	Physi this c	2	1 Yes 2 No	1 Inpatient 2 ER/	Outpatient				ence 6 Other (Spe	cify)
o uo	nding tth. : After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury at work?  M 1 \sum Yes		sa, Describe no	w injury occurred	
Division of Vital Records,	Atter	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office	2		reet and Number or Ru	ural Route Number,
Ö	oital or urs aft ral Dir							City or Town		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certifical completed filled in by the funeral director, p.	Medical	(Check   2   Medical Examine	ian: To the best of my knowledg r: On the basis of examination and Practioner: To the best of my kno	d/or investi	gation, in my opinion, de	eath occurred at t	he time, date and	d place, and due to the	cause(s) and manner stated.
	To the within To the сопр	2	29b. Signature and title of certifier	Tactioner. To the best of my kind	owieage, ac	29c. License num			9d. Date signed (Mont	
	3		NUVU	1		MD 3	1414		05/10/	12
	Vie		30. Name and address of person who com	npleted cause of death (Item 23a	a) (Type, Pr	D IRVIN	C+.CT	NN 2	A50 INCA	itt. DC 20010
150.	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	- +1 3/11	. 4 9 1		, - VV)	UIII
	Registra	ır	MAI I WUIZ Chase	u D. Dark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 17 3:20PM <sup>M</sup> Stuart Rosenbaum Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Lorien Mays Chapel Timonium If Under 1 Year If Under 24 Hrs. .8. Date of Birth (Month, Day, Yea Sep 25. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** 1 QM 2 DF Days Hours Director -5865 87 23a or 28a-f show ast be notified at 10a. State filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD **Baltimore** Timonium 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? Funeral 21093 USA 12230 Roundwood Road items 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. or, þ 1 Never Married 2 Married limore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced WW II white Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72. sath and Mental Hygiene.
127 is marked other than "r rraumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Rosenbaum's Dept.Store 12 <u>Co-owner</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Esther Bamberger Morris Rosenbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12240 Roundwood Rd. #202 MD 21093 Timonium I and 2 s I Health Item 27 Louise Miller sister item 2 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, XBuriaL 2 ☐ Cremation \3 ☐ Removal from State 5/20/2012 East View Cemetery MD 4 Donation 5 Other (Specify) Cumberland 21. Signiture of Funeral Service L 22. Name and Address of Facility
Scarpelli Funeral Home, PA Scarpelli Funeral Home, PA
108 Virginia Avenue: Cumberlar
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Physician/ 142 Medical Examiner Sequentially list conditions, if any, leading to immediate course. Enter Uncertains Examine Due to (or as a consequence of) Cause (Disease or linjury as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be ivision of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Pregnant at time of death Year Day detached 1 ☐ Yes ∠ L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 Probably 4 Unknown DISLARE 1 🗌 Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
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the Funeral the

30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. 31. Date filed (Month, Day, Year NAY 3 0 2012 State

one)

Medical

Homicide

29b. Signature and title of certifier

Assistant Medical Examiner 32. Registrar's Signature

(Specify) Front Deck

and manner stated.

determined

UUME

1953 hrs

MD 21555

Approximate Interval

Between Onset and

Death

Year

2 No

29d. Date signed (Month, Day, Year)

May 13, 2012

MD

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Registra

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2012 1747 Daniel Randall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u> Anne Arundel Medical</u> Arunde1 Center <u>Annapolis</u> <u>Anne</u> 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Director 217-30-4514 1 **X** M 2 □ F 99 Yrs. Oct 10 1912 Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No Harwood Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4450 Lansdale Rd. 20776 USA items ; within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify If Yes, Give Year or Dates "natural", **Black** 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 3rd 0 <u>Farmer</u> <u>Lansdale Farm</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once. ဂ Solomon Randall Mary Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Randall(Daughter) 4450 Lansdale Rd. Harwood, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5-15-12 West River, Md. Chews U.M. Church ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Williame Reeser ReilitSons Mortuary, 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) neumoni Dre Weell Medical Due to (vas a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death be detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe Yes 2 No 2 🗌 No funeral director, 25. Was case referred to make Be 26. Place of Death (Check only one) examiner? 2 No Other: ျင 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, 24 hours after death. Funeral Director: After Hospital or Attending filled in by the within To the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 32/Registrar's Signature MAY 1 0 2012

State Registrar

DHMH 17 Rev 06-2011

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Freeman Leroy Royal May P  $^{\mathsf{M}}$ 6:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 171 Simmers Road Cecil Rising Sun Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗓 M 2 🗆 F Months Days Hours Min Director 213-46-3657 65 VA Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 171 Simmers Road 21911 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1966–68 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Relief Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Freeman Royal Carrie Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Royal/wife Simmers Road, Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 
Burial 2 X Cremation 3 
Removal from State 05-14-2012 me, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD Foard Funeral Home, 21. Signature of Fureral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. ( 111 S. Queen St., Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ PROBABLE MYOCARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to jor as a consequence of and -tran: resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year 4 Pregnant at time of death 2 🗆 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, DYSLIPIDEMIA 1 ☐ Yes 2 D No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC KIDNEY DISEASE 24a. Was an performed' 1 Yes 2 No Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 24 hours after death.

e Funeral Director: A pleted filled in by the fu Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760

10

within 2 To the F

State

Medical

29a, Certifier

29b. Signature and title of pertific

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D45344

AVE, IHAVRE DE GRACE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Henry	Edward	Romani	
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21		4		1	0	0	6

		1- For State Registrar	Ce	rtificate of	Death		R	<i>∠</i> ∪ 1 eg. No.	
Physicia Medical Exami	ın/	Decedent's Name (First, Middle,Last) H	enry E. Rom				2. Date of Dea Month May 4, 20	th Day Year 12	3. Time of Death 0949 hrs
		4a. Facility Name (if not institution, give stre 2703 Pebble Beach Drive			b. City, Town, or Elkton			4c. County of Deat Cecil	
Funeral Director		5. Social Security Number 6. Sex 119−26−5450 1 M	7. Age (In yrs. 2 78	last birthday) Yrs.	If Under 1 Yea Months Days		rs. 8. Date of Bir lin. 10/27/	Forei	thplace (State or gn Puntry) New York
id how any		Usual Residence of Decedent  10a. State 10b. County  Maryland Cecil		, Town or Location	on				10d. Inside City Limits 1 X Yes 2 No
the Maryland 3a or 28a-f show	Directo	10e. Street and Number  2703 Pebble Beach I		TREON	10f. Zip Code 21921		1	Og. Citizen of What Cou	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	1 X Never Married 2 Married	Yes 2 No	- N V	Decedent of Hises, specify Cuban	, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
36 in 72 hours af han "natural lical Examin	Completed by			16a. Decedent during mo	's Usual Dccupat st of working life.	ion (Give kind o . DO NOT use n	etired)	16b. Kind of Business/	Industry
215-003 be filed withintal Hygiene. rked other ti	Be	17. Father's Name (First, Middle, Last) John Romani		Frec	trical F	18.Mother's Nar	ne (First, Middle, I ed Minich		ce
MD 21 nd 2 should I alth and Mer m 27 is man	٩	19a Informant's Name/Relationship (Type, F Emily Cargulia/Sist 20a Method of Disposition	er		Hilltop	Road, N	Mahwah, N		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "astural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Burial 2 Cremation 3 Red     Donation 5 Other Specify:     Signature of Funeral Service Licensee	moval from State	crematory or oth . Charle	erplace) s Cemete	ery 20	ay <sup>D</sup> , 012 icks Home	20c. Location - City or Pinelaw For Funer	n, NY
M		23a. Part I. Enter the disease, or complication			103 W. S	Stockto	n Street	, Elkton, M	D 21921 Approximate Interval
Examiner			ertensive Atherosc o (or as a consequence o		ovascular Dis	ease			Between Onset and Death
d sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	o (or as a consequence o						
760, icate be executed physician and the burial - transit	adical		ENDED						
O.O. Box 68760, that the death certificate be need by the attending physici detached for use as the burn	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of preg Live birth Pregnant at time of de Unknown	2 Feta	al death 3 [ er (Specify)	Ectopic preg	nancy	23d. Date of deliver	V Day Year
S, P.O. F Lires that the 1 signed by the d be detached	à	Part II. Other significant conditions control	ibuting to death but not r	resulting in the ur	nderlying cause g	iven in Part I.		obacco use contribute to	
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifivithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed	-					1 Yes		topsy findings available completion of cause of
Vital sysician: this certif	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	II: 1 Inpatient 2	ER/Outpatient		of Death (Chec		Residence 6 🗸 Othe	r: Scene
Division of Vipital or Attending Phours after death.  erral Director: After tiffled in by the funeral		2 Accident S Pending Investigation	Ba. Date of Injury (Month, Dey,Year)	28b. Time of In	1 Y	y at Work? ′es 2 No	28d. Describe I	now injury occurred	
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Certification:	Suicide Could not be determined  Homicide determined	8e. Place of Injury - At h				or Town, S		
To the Hospital Within 24 hours To the Funeral completely filled	edica	one) 2 Medical Examiner: On the				death occurred			e cause(s)
		30. Name and address of person who compl	tellu .	n 23a)	O.C.1	И.Е.		May 5, 2012	
18+IVA			Assistant Medical	Examiner 9	C-17.7	nore Street,	Baltimore, M	O 21223	
Regist	_	MAY 8 2019	A Signal Solgilati	A. San	Kal				

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Joseph E. Rosenberg 2012 1950 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Hours 187-01-8382 **Director** 1 X M 2 D F 94 Yrs June 08, 1917 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Prince George's Silver Spring 1 Yes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 20904 3142 Gracefield Road, #413 u.s.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Juld be now.
Id Mental Hygiene.
In marked other than "natural", or item 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Specify: Completed WWII White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturer's Representative Furniture Be permit. Page 1 and 2 should be filed Department of Health and Mental H. Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ida Berman Harry Rosenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. Rosenberg - Son 1675 North Beverly Glen Blud., Los Angeles, CA 90077 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Ft. Lincoln Crematory 05/10/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. mehrod 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph. sician Pneumonia Medical Due to (or as a consequence of): Examine Atrial Fibrillation Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury ial-tan that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buria as the bur Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 L 9 Unknown P.0. signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, been sig should b 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed?

1 Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ပ္ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 XNatural 5 Pending work? 2 No within 24 hours after death

To the Funeral Director: A

completely filled in by the Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D59524 2041 May 08, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, Maryland 20904 Loveen Puthumana. M.D.

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Karen Elizabeth Ro	osenblatt 1- For State Registrar	State of Marylar		rtment of I tificate of L		Mental H		eg. No. 2 (	012 1708
Physician Medical Examine	Decedent's Name (First, M.	<sub>liddle,Last)</sub> aren Elizabe	eth Rose	enblatt			2. Date of Deat Month May 10, 20	th Day Year	3. Time of Death 1512 hrs
	4a. Facility Name (if not instit		nber)		City, Town, or Le	ocation of Deat		4c. County of Howard	Death
Funeral Director	5. Social Security Number 215 68 1359	6. Sex 7	7. Age (In yrs. Ia	ist birthday) Yrs.	Months Days	If Under 24Hr Hours Min			Birthplace (State or Foreign Country)
any	Usual Residence of Deceden  10a. State 10b. Cour	nt		Town or Location			12/30	7 1 3 3 0	10d. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once.	MD H	oward	Ell	Licott C	ity Of. Zip Code		10	Og. Citizen of Wha	1 Yes 2 No
with the N is 23a or 2 c notified			dent Ever in U.S	S. 13. Was D	21042 ecedent of Hispa		pecify Yes or No-	United	States American Indian, Black,
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must he notified at once feed by Furneral Director	3 Widowed 4	Divorced If Yes, Give Year or Dates:	2 X No	If Yes,	specify Cuban, I	Mexican, Puerto	o Rican, etc.)	White,	etc. White
5-0036 cd within 72 hours lygiene. other than "nature Medical Exam	15. Decedent's Education (: Elementary/Secondary (0-				Usual Occupatio of working life. D Manage	OO NOT use ref		16b. Kind of Busi	uction
	Kenneth Gegn	idie, Last) er			18	M. Eli:	e (First, Middle, M zabeth R	raiden Surname) eed	
MD 21 d 2 should th and Me n 27 is ma numatic co	Roger Rosenb			2222 M	ount Heb	oron Dr			y, MD 21042
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental important: If item 27 is marked nijury or other traumatic event, To Be	20a. Method of Disposition 1 X Burial 2 Crema 4 Donation 5 Other	_	m State cr	lace of Disposition rematory or other John 's	place)	- 1	Date 15-2012		city or Town, State
Baltimo permit. Page Department of Important:	21. Signature of Funeral Ser								amily FH Inc. itv, MD 21043
Physician /Medical Examiner	23a. Part I. Enter the disease failure. List only one car Immediate Cause (Final dise	use on each line.				uch as cardiac o	or respiratory arre	st, shock, or hear	t Approximate Interval Between Onset and Death
har-pri	or condition resulting in death	b							
ted nisit Examiner	if any, leading to immediate cause Enter Underlying Cau (Disease or injury that initiate events resulting in death) La	ed <sup>C.</sup>			_				
0, be executed siscian and burial - transit	UNPENDED	d AMENDED		-					
6876 certificate noding physise as the clan/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 ✔ No 9	in the 1 Live birt	nt at time of dea	2 Fetal	death 3 (Specify)	Ectopic pregna	ancy	23d. Date of d	elivery Day Year
P.C es that igned l	3	iditions contributing to c	eath but not res	sulting in the und	erlying cause give	en in Part I.			ute to the cause of death?  Probably 4 Unknown
Records The law requicate has been page 2 should							24a Was a autops perform	sy pri med? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital   ysician:	25. Was case referred to med examiner?	Hospital:	patient 2 E	ER/Outpatient 3		Death (Check		Residence 6	Other Seens
⊏ #ੂੈ ਪੋਟੀ ਨ	27 Manner of Death	28a. Date of (Month, D	f Injury	28b. Time of Injur	y 28c. Injury			ow injury occurred	
. (⊈ઙ૽ઙ૽૱  <u>છ</u>	2 Accident Ir 3 Suicide 6 C 4 Homicide	could not be letermined (Specify)	of Injury - At hor	me, farm, street, f	actory, office buil	ding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
Div To the Hospital or within 24 hours after To the Funeral Dir completely filled in		g Physician: To the best of Examiner: On the basis of and manner sta	examination and						
	29b. Signature and the of cer	Ita.	Vecs	100	29c. License r O.C.M.			29d. Date signed May 10, 201	(Month, Day, Year)
10	30. Name and address of per- Victor Weedn MD J	D Assistant Medi	,	•	altimore Stre	eet, Baltimo	ore, MD 2122	3	
State Registra	e 31. Date filed (Month, Day, Ye	ar) 32. Regi	istrar's Signature	A bar	الما		-		

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar		-	partment of I partificate of		Reg.	2012	17065
sician	1. Decedent's Name (First, Middle, La	R. Riden	01176				Day Year	3. Time of Death
edical	Marguerite		lour	45 Cit. T.	and another of Dank	05 16	2012	1:13 P M
miner	4a. Facility Name (If not institution, given Coffman Nursing				or Location of Deat CSTOWN		4c. County of Death Washingtor	
ral	5. Social Security Number 6. S		(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs	8. Date of Birth		lace (State or Foreign try)
tor	217-18-7927	1□M 2 <b>/</b> □F	90 Yrs.	Months Days	Hours Min.		921 Clear	Spring, M
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Landina				0d. Inside City Limits
5			-				1	1 X Yes 2 No
once.  To Be Completed by Funeral Director	MD Washing	gton	Hagerst	10f. Zip Code		100	Citizen of What Coun	
흐	1304 Pennsylvan:	ia Ave.		21742			US	u y r
Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 1	B. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S		14. Race - Americ	
클	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 N	0	If Yes, specify Cut		to Rican, etc.)	Black, White,	
d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1LIYES 2LAINO	Specify:		Specify: whi	.te
Completed	15. Decedent's E (Specify only highest gr		16a. De (G	cedent's Usual Occu ve kind of work done . DO NOT use retire	pation during most of wo	rking 16b	. Kind of Business/Ind	dustry
Id m	Elementary/Secondary (0-12)	College (1-4or 5-	-)		ed)		. 1	
	12 17. Father's Name (First, Middle, Last	•)	C10	erk	18. Mother's Na	me (First, Middle, Mai	jewelry s	tore
o Be	Herbert R. McA				Lydia S			
5	19a. Informant's Name/Relationship		19b. Ma	iling Address (Stree		ural Route Number, Ci	ty or Town, State, Zip	Code)
	Jack McAlliste	er/brother	124	448 Ashton	n Rd. Cle	ar Spring,	MD 21722	2
	20a. Method of Disposition	_	20b. Place of Dis	position (Name of rematory or other pla	ace)	Date 200	. Location - City or To	wn, State
	1 X Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Speci		1	11 Cemete		L/2012 Wa	ynesboro,	PA
	21. Signature of Funeral Service Lice	75 <b>9</b> 0		22. Name and Addr	ess of Facility	Grove-Bowe	-	
1	Thus It	Same		50 S. Bros	id St. W	aynesboro,	PA 17268	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):					
Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 Fetal death	B⊟Ectopic pregnanc	ey		23d. Date of delive Month	ery Day Year
by P	Part II. Other significant conditions	-	15		ven in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
ed	Myzerlensin	re hear	t du	erro		1 🗆 Yes	2 <b>⊅</b>	ably 4 □Unknown
Completed						24a. Was an autopsy performed	prior to con death?	psy findings available npletion of cause of
Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only one)		
atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inju	4 vursing i	dome 5 Residence 28d. Describe how i		Y)
Certification:	3 ☐ Suicide 6 ☐ Could not to determined	building, etc	. (Specify)	street, factory, office		City or Town, S		
edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best o miner: On the basis of and manner sta	examination and/or	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occ	urred at the time, date	and place, and due to	the cause(s)
Σ	29b. Signarure and title of cettifier				se number	1	Date signed (Month,	* '
	le les	200	~	(T)	00632	-33 0	5/17/2	20/2
	00 11 1 11 / 1-	completed seven of de	eth (Itam 03a) (Ten	- D-:-4\			, ,	
State	30. Name and address of person who  Jack Ma  31. Date filed (Month, Day, Year)	hunden		C NOT	Chern t	The Has	er Hown M	10/2 10/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Μ. Schaller, Sr. 11:55 A 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Sunrise Assisted Living Severna Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1**⊠** M 2□ F Months Days Hours Min 91 189-03-2707 Director Oct. 21,1920 Pennsylvania Usual Residence of Decedent 10b. County show 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the "Modical Examinar must be notified at Anne Arundel MD Severna Park 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or USA 41 W. McKinsey Road # 235A 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 50 Yes 2 □ No If tes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Insurance Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice C. Schaller Eleanor Treshmann ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 W. McKinsey Road # 235 A Severna Park, MD 21146 Marjorie Schaller/ Wife Pages 1 ament of H 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o May 10, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2012 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service License 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediate Cause (Final disease or condition resulting in death) **Physician** ere brovascular disc /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Assisted Low Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number rsneg D57531 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Negi Velerans Millersville 31. Date filed (Month. 32. Fegistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Amend #5 per FD Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO Health Deptt: 5-16-12 KAH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month 10<sup>3y</sup> 2012 03:35 PM Elizabeth C. Schnaubelt Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collington Life Care Center Prince George's Mitchellville 6. Sex Funeral \$25-20-8856 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F 0470371917 **Director** 95 Illinois Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland Mitchellville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral 10450 Lottsford Road 20721 United States Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "matural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black White etc. Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Specify: White Year or Dates Department of Health and Mental Hygiens Indoordant; If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Public Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Andrew Flannigan Elizabeth Lentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Schnaubelt/Son 302 Spring Mount Knoll, Spring Mount, PA 19478 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Kalas Crematory 1 Burial 2 X Cremation 3 Removal from State 05/13/2012 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Ohset and Death Immediate Cause (Final Physician/ 9 W 9 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) g physician and is the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year the 9 Unknown 9 I IInknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1/5/oren 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown 24a. Was an /24b. Were autopsy findings available prior to completion of cause of death? 24 hours after death.

Funeral Director: After this certificate has I sted filled in by the funeral director, page 2 s performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 1 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title, of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luck Rt. 7300 Landen mo Alla Sons ردي 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death May 9 Physician/ Ford Snodgrass 2012 Henry 9:45P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Anne Arundel Medical</u> Center Annapolis Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Min. (Month, Dav. Year) 230-28-9180 Director 1 X M 2 □ F 85 9/19/1926 Virginia Usual Residence of Decedent show 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f sl 1 Tes 2 X No Maryland Anne Arundel Riva 10e. Street and Number 0 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funeral USA 3022 Marlin Drive 21140 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter Armed Forces or i Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Divorced 4 Divorced Year or Dates. 1945-46 e 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5 College (1-4 or 5+) Plastics Inspector/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leonard R. Snodgrass Laura Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3022 Marlin Drive, Riva, MD 21140 Department of Health Important: If item 27 any injury or other to Louella M. Snodgrass/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Cemetery: 5/14/12 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician | disease or condition Ischemic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): the burialsigned by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Vear Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) epher

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 9, 2012 Isabel P. Strawderman 11:05pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House-Montgomery Hospice Montgomery Rockville Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🛣 F Months Days  $Feb^{(Month, Day, Year)}$ Hours Min Director 80 Washington, DC 579-40-2063 Usual Residence of Decedent or 28a-f show notified at the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Gaithersburg 1 Yes 2 X No Montgomery ō 10e. Street and Number ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 429 Christopher Avenue #22 20879 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Examiner Armed Forces or by 1 Never Married 2 Married Je filed within ,— ential Hygiene. arked other than "natural", o-~ent, the Medical Exar Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give 1 Yes 2 No Specify. Specify: White 3 x Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) 12 2 should be filed with and Mental Hygien 7 is marked other the Bank Teller Banking traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Peter DeStefano Mary Derogatis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Linda L. Piccioni (Daughter) 429 Christopher Avenue #22, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Dato, Department of Important: If it any injury or o Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home East Deer Park Drive tert Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 e attending p d for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month the P.0. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 ☐ Yes 2 🔀 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗓 Other (Specify) Hospice this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Debrah Miller,

MAY 1 4 2012

31. Date filed (Month, Day, Year)

20

6001 Muncaster Mill Road, Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Saul Strauch 4:40ам May 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6101 Robinwood Road Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 117-18-3478 1 X M 2 □ F Director 86 June 11,1925 New York Usual Residence of Decedent 28a-f shov 0a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6101 Robinwood Road 20816 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner rmed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Specify. Completed 1945 White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Company 5+ Physicist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Benjamin Strauch Ida Suransky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health ar Important: If item 27 is any injury or other trau Judith Strauch - Wife 6101 Robinwood Road, Bethesda, Maryland 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 💆 Removal from State Adas Israel Cemetery 05/13/2012 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MO1024 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure one cause on each line Interval Between Immediate Cause (Final Onset and Death

13 Months Physician/ Multiple Myeloma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Month Pregnant at time of death Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No 1 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Registrar

10

29a. Certifier

(Check

only one) 29b. Signat

and title a

Ralph Boccia,

MAY 14 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D29675

6420 Rockledge Drive, #4100, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

May 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Ada Mayberry Smith 2. Date of Death Physician/  $30^{pay}$ 11:30 PM 2019 Medical a Facility Name (if not institution, give street, and number) Washington Adventist Hospital 4c. County of Death Examiner 4b. City, Town, or Location of Death Takoma Park Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 DC Social Security Number 578-60-5939 **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F Months Days Hours 1277 16 /en 931 Director Usual Residence of Decedent rene. It than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10c. City, Town or Location
Washington filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No 10e. Street and Number 4744 Benning Rd. 10f. Zip Code 2001 9 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1X Never Married 2 ☐ Married 1 Yes 2 If Yes, Give Saltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) unknown unknown Be 17. Father's Name (First, Middle, Last)
Garrison Smith 18 Mother's Name (First, Middle, Maiden Surname) Hazel Lena Magruder 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
99 Bellevue St. SE Washington DC 20032 Hazel W. Mosby/daughter 899 Bellevue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Washington Nation 5/9/12 Suitland, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 5635 Eads St. NE Washington DC 20019 MO1388 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Unknown Unknown 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performi 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ျ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suicide4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direc Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600

State

Registrar

Date filed (Month, Day, Year)

8-2012

			1 - State Registrar	State of Marylan		tificate of l		vieritai riy	Reg. 1		
Physiciar Medica			1. Decedent's Name (First, Middle, Last JANNIE SUM	ot) MERS				2. Date of De	eath	B <sup>ay</sup> 20 <b>Y</b> 2	3. Time of Death <sub>A</sub> 12:44 M
4.0	Examir	ner	4a. Facility Name (if not institution, give street and number) APEX HEALTH of SILVER SPRING			4b. City, Town, or Location of Death Kensington			4c. County of Death Montgomery		
	Funeral Director		370 20 4322	ex 7. Age (In yrs. le	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug 15	th ay, Ye <i>ar</i> 19	g. Bir Co 10 <b>Sout</b>	thplace (State or Foreign untry) h Carolina
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin							10d. Inside City Limits 1 ☐ Yes 2 No	
		a D	10e. Street and Number	• -		10f. Zip Code	_		10g.	Citizen of What Co	ountry?
21215-0036		Funeral	2805 Erie Street	12. Was Decedent Ever in U.S	10.1	2002		!fVN-		.S.A.	
		Completed by F	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecity yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify:31a	e, etc.
15-		nple	15. Decedent's E (Specify only highest gr	ade completed)	(Give I	lent's Usual Occup kind of work done ( O NOT use retired)	during most of work	king	16b.	Kind of Business	Industry
212		To Be Cor	Elementary/Seconday (0-12)	College (1-4 or 5+)		lorker			Pri	ivate	
pu			17. Father's Name (First, Middle, Last)	<u> </u>			18. Mother's Nan	ne (First, Middle,			
ryla	uld be I Ment narke natic		John Anthony					Hartzog			
Maryland	permit. Page 1 and 2 sho Department of Health and Important: If item 27 is r any injury or other traun		19a. Informant's Name/Relationship (7) Paula Mack, Nei		1		and Number or Rui				
Baltimore,			20a. Method of Disposition  1 🛣 Burial 2 🗆 Cremation 3 🗆 4 🗀 Donation 5 🗀 Other (Specie	Removal from State	lace of Dispo	sition (Name of	oad, S.E. ark 05/1	Date	20c.	Location - City or ndover,	Town, State
Balti			21. Signature of Funeral Service Licens	see	333 62	. Name and Addre	ss of Facility HA	LL BROTI	HERS	FUNERAI	HOME
	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Is chemic Cardiac Arrythmia  Ischemic Cardiac Arrythmia								
	The law requires that the death certificate be executed to the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit of	r.	Sequentially list conditions,	Due to (or as a consequ				———			
. Box 68760		Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):							
			resulting in death) Last	Due to (or as a consequence of):  d							
		Med	IF FEMALE:								
		hysician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown	23c. If yes, outcome of pregnar  1  Live Birth 2 Fetal  4 Pregnant at time of d  9 Unknown	Ideath 3	Ectopic pregnand Other (specify)	су			23d. Date of de Month	ivery Day Year
P.0			Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
ďs,		ted	Hypertension			1 🗆	Yes	2 <sup>X</sup> □ No 3□ P	robably 4 🗌 Unknown		
Recor	sician: The law re certificate has be irector, page 2 sh	Completed by	Glaucoma							prior to death?	topsy findings available completion of cause of
ita	ading Phy ath. r: After this ne funeral d	Be	25. Was case referred to medical examiner?  1  Yes 2 No Other: Ot								
.≥		e: <b>T</b> o	27. Manner of Death	28a. Date of injury	200. Describe flow injury occurred						ify)
		fical	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation	De 280 Place of laiun. At home form of		work? 1 Yes 2 No					
	tal or Attencrs after death	Il Certificate:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined			eet, factory, office		28f. Location (Street and Number or Rura City or Town, State)			ral Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
			29b. Signature and title of certifier	m			e number 59951		29d. C May	Date signed (Monti 11 201	
	Ψ,			15245 Shady Gr	ove Ro	oad, Rock					
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signate	ure	MAY 1 5	2012	wa ,	1.	pare	

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **6**5 0 gay Earl Thomas 20<sup>Year</sup>2 5:05am M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George Hospital Cheverly Prince George 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Days 577-64-4334 Director 06/05/47 1 X M 2 🗆 F 64 Washington, DC Usual Residence of Decedent 'item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3615 Alabama Ave SE 20020 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Black Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene.
7 is marked other than "1 life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 11th Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke. any injury or other traumatic e Lamar Thomas Doris Mae Goodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon Knott Son 4604 Lacey Ave Forestville, Md 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 05/15/12 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Glenwood 21. Signature of Funeral Service Licenses 22 Sine add funfeiral Home & Cremation 0777 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ CARDIAC FATAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami physician. CORON ARY Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) physician To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending networks Physician/Medical Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day the a Yes 2 No 9 Unknown 9 Unknown P.O. be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performe 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death Certificate: Date of injury 28b. Time o 1 Natural 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Accident 1 Yes 2 No Investigation M filled in by the after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 30-Hame and address of person who completed cause of death (Item 23a) (Type,

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Henry Louis Than		Jr. 1- For State Registrar	State of Maryla	and / Depa	artment		n and Ment		Reg. No.	12 1707		
Physicia Medical Examin	n/	Decedent's Name (First, Menry	Aiddle,Last)	Tha	arps,	Jr.		2. Date of D Month May 12,	eath	3. Time of Death 2121 hrs		
		4a. Facility Name (if nof inst 8930 Woodyard R		ımber)		4b. City, To	own, or Location of		4c. County of D Prince Geo			
Funeral Director		5. Social Security Number 219–72–5054	6. Sex	7. Age (In yrs. I	=1	If Under Months			Birth (MM/DD/YYYY) 9.	Birthplace (State or oreign Country) Wash DC		
ow any	-	Usual Residence of Decede 10a. State 10b. Cou	inty		Town or Lo					10d. Inside City Limits 1 🛣 Yes 2 No		
e Maryland or 28a-f sho	Director	Md.  10e. Street and Number  5917 Plata	P.G.		Linton	10f. Zip (	20735		10g. Citizen of What Country? U.S.A.			
er death with :	Funeral	11. Marital Status 1 Never Married 2		2 X No		f Yes, specify	t of Hispanic Origi	in? ( Specify Yes or I Puerto Rican, etc.)	No- 14. Race - Ar White, et	merican Indian, Black, c. Black		
36 in 72 hours aft han "natural"	Completed by	15. Decedent's Education (  Elementary/Secondary (0-  12th	Specify only highest grad	de completed)	16a. Deced	dent's Usual O most of work	ccupation (Give king life. DO NOT u		16b. Kind of Busine United St			
1215-0036 be filed within 7 mtal Hygiene. rrked other than vent, the Medica	å	17. Father's Name (First, Mic	L.	Tharps	-		18.Mother's	-	, Maiden Surname) Willi	lams		
MD 21 nd 2 should I aith and Mer m 27 is mar		19a. Informant's Name/Relate Tanya Tharps			591	7 Plata	a Street	, Clinton	umber, City or Town, S , Maryland	20735		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		20a. Method of Disposition  1 X Burial 2 Crem.  4 Donation 5 Othe	r Specify:	om State	crematory or SUFFEC	tion C	emetery		20c. Location - City	n, Md.		
	1	7. Signature of Funeral Ser	aug #	ausad tha death	1	0583 M	iddlepor	t Lane, W		s, Md. 20695		
Physician /Medical Examiner		failure. List only one ca Immediate Cause (Final disc or condition resulting in deat	iuse on each line. ease a. <mark>Multiple Inj</mark> i			- the mode of		rulac of respiratory a	niest, shock, of fleat	Approximate Interval Between Onset and Death		
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50, te be exect ysician an burial - tr	edica	UNPENDED	AMENDED						Inc. p			
Box 68760, e death certificate be exuch the attending physician ed for use as the burial.		FEMALE:   23c. If yes, outcome of pregnancy   2   23c. If yes, outcome of pregnancy   2   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (Specify)   9   Unknown   9   Unknown   1   Unknown   1   1   2   2   23c. If yes, outcome of pregnancy   2   23c. If yes, outcome of pregnancy   2   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   2   2   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   2   2   2   2   2   2   2   2   2							23d. Date of deli	very Day Year		
s, P.O. ires that the signed by	2	Part il. Other significant co	nditions contributing to	death but not re	esulting in the	e underlying c	ause given in Pan		tobacco use contribute es 2 No 3 F			
tal Records, cian: The law requir certificate has been sector, page 2 should	Completed							1 ✓ Yes				
Vital hysician: This certif	ě	25. Was case referred to me examiner?  1 ✓ Yes 2 No	Hospital: 1 1		ER/Outpatie	ent 3 DO		Nursing Home 5	Residence 6 🗸 O	ther: Scene		
	ertification:	2	ould not be	.Day Year) 2012			c. Injury at Work?  1 Yes 2 I	Operator of tractor-trail  28f. Location or Town.	er (Street and Number or	that collided with a  Rural Route Number, City MD		
To the Host within 24 he To the Fun completely in	ا ق		g Physician: To the bes Examiner:On the basis of and manner s	of examination ar								
	Ž [	29b. Signature and title of ce		20)			D.C.M.E.		29d. Date signed () May 13, 2012	Month, Day,Year)		
Ψ,		30. Name and address of per Pamela E. Southal	I, MD Assistant	Medical Exa	miner 9	00 W. Balt	imore Street,	Baltimore, MD	21223			
Stat Registra	te	31. Date filed (Month, Day Ye	32. Re	gistrar's Signatu								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Presley S. Taylor, Jr. May A M 2012 7:45 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year,
April 12, **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 219-12-3389 **Director** 1 XM 2 D F 88 1924 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Crofton 1 🗌 Yes 2 🔀 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be r items 23a Funeral 1620 Angus Court 21114 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ian "natural", or iter Medical Examiner 14. Race - American Indian. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XXIo Specify: White Specify 3℃Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the Executive Marine Electronics 12 other 1 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic eveni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Presley S. Taylor Marguerite Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1620 Angus Court Crofton, Maryland 21114 Judy Snyder/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Fremation 3 Removal from State Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 5/10/2012 Baltimore, Maryland weral Sirvice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatur a 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ ardice disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in medicause. Enter Underlying disease Exami Cause (Disease or injury that initiated events Corona and Due to (or as a consequence of) resulting in death) Last the attending physician ched for use as the buna Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Propably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CKO 24a. Was an has or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Ceath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

the

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

30. Name and address of person

MAY 09 2012

31 Date filed (Month

of death (Item 23a)

29d. Date signed (Month, Day, Year)

21401

Annalis MO

010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last, 2. Date of Death Physician/ 1010 A M Medical **Examiner** City, Town, or Location of Death County of Death If Unde 7. Age (In yrs. last birthday If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Alugth, D3(1 , 1944 1 M 2 WF Washington **Director** 150-34-8507 67 Usual Residence of Decedent 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Rockville Maryland Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 929 Farm Haven Drive 20852 United States items within 72 hours after death 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify. white Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Public School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Florence Norman Linde Ravitz 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Boute Number City or Town State 719 Code) Ira Tyler, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 05/11712 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Garden of Remembrance Memorial Park Clarksburg, MD Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence o): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): the burial attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death should be detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Month 5 Other (specify) Pregnant at time of death Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 21 No death? After this certificate 1 Yes 2 No \_\_ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Tyes 2 🗌 No 2 Accident
3 Suicide completed filled in by the Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Obs State 0 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LURA WRIGHT  $\mathbf{a}^{\mathsf{M}}$ MAY 2012 6:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chester River Manor Chestertown Kent Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** OCE 2 Par Sear Months Hours Min 95 Delaware Director 222-07-5980 Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ient, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Kent Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14081 East Beechwood Rd. 21635 U.S.A. within 72 hours after death 11 Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Co-Owner - Operator Marine Store 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F Howard Hudson Beatrice Carlise and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Boute Number, City or Town, State, Zip Code) Sam Wright (son) 14081 East Beechwood Rd. Galena, MD: 21635 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State Kent Cremation Service 4 Dopation 5 Other (Specify) 5/14/12 Smyrna, DE. of/Funeral Sen 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech Signath M00510 118 West Cross St. Galena, MD. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death neart failure. List only one cause on each line. Immediate Qause (Final DEMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No 9 Unknown Month Year Pregnant at time of death Day 5 Other (specify) the 9 Unknown P.O. à s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 1 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed certificate Hospital or Attending Physician: 25. Was case referred to fiedical funeral director. Be Division of Vital 26. Place of Death (Check only one) examiner? 2 🖸 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After Natural 5 Pending work? 24 hours after death. Funeral Director: A 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Description Nurses Practioner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifyin Nurses Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 28b. Signature and title of cert 29d. Date signed (Month, Day, Year) 12 1/W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Shanahan Chestertown, MD. M.D 120 Speer Rd 31. Date filed (Month, Da 32. Registrar's Sign

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0123 2012 Patricia Ann Willard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Sept. 5, 1947 Hours Director 212-50-9202 1 M 2XX 64 Maryland Usual Residence of Dec 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Washington Hagerstown 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? 23a ( Funeral 15207 National Pike Apt. I 21740 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Examiner 14. Race - American Indian, Armed Forces 2 Black White etc. Completed by Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 1 Yes 2 X No Specify. If Yes, Give "natural", Specify Year or Dates White traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) filed within al Hygiene. College (1-4 or 5+) 12 marked other Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental ပ Elwood Maynard Carbaugh, Sr. Anna Mae Murray and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I and 2 s F Health Mary E. Socks - Sister 21 W. Potomac St. Williamsport, Maryland item 2 20a. Method of Disposition

1 

Burial 

Cremation 3 

Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place, Hagerstown Crematory May 19,2012 Hagerstown, Maryland 4 Donation Other (Sp 21. Sig ture of Finer Lin 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Myocardial Onset and Death Ph si i n disease or condition resulting in death) Medical Examiner heart disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events resulting in death) Last physician a the burial-Physician/Medical requires that the death certificate be P.O. Box 68760 as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 Yes 2 No Day Month Year the 9 Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mabetes Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed Medical non-compliance 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page . Hypertension performed? Yes 2 No certificate 1 Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? After 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending death. 1 Yes 2 No Accident Investigation Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o 29c. License number M.D.

Registrar

DHMH 17 Rev 06-2011

30. Name and address of

Howell

person who completed cause of death (Item 23a) (Type, Print)

7.33

allah

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G928 6/25/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5/12/2012 Day Year 3:20 P Janice Marie Wienhold Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin 78 Bird Nest Dr. If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security 2180 . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD<sup>Country)</sup> 1 □ M 2**X**□ F Months 2/15/1953 214 48 <del>2185</del> Director 59 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f st aumatic event, the Medical Examiner must be notified i Berlin MD Worcester 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21811 78 Bird Nest Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1X Never Married 2 ☐ Married 21215-0036 white 1 Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) mental health field Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic eve ည Dorothy Gunning John F. Wienhold, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
78 Bird Nest Dr. Berlin, MD 21811 Jonathan Wienhold (son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5/16/2012 Dagsboro, DE Gate of Heaven Cem. 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the Josease, or complications that caused shock, or heart follure. List only one cause on each line ath. Do not enter the Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death certificate has been signed by the rector, page 2 should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending I 24 hours after death. 1 V Natural 5 Pending injury 1 Yes 2 No Accident Investigation 24 hours after deatl Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature 29d. Date signed (Month. Dav. Year) Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Clara Wilson 2012 2:05 A.M May Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wilson Heath Care Center Gaithersburg Montgomery Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Mir 009-07-2992 Director 1 □ M 2 🔀 F 99 March 6,1913 PAUsual Residence of Deced items 23a or 28a-f show ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 X No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 301 Russell Avenue United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 nan "natural", o Medical Exan 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry The filed within all Hygiene. There than "n. "the Meritan "n. "t, the Meritan "n. "the Meritan "n. " (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi. Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatin and injury or other traumatin Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Olive Susan Guthrie Frederick Moyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred L. Wilson (Son) 1315 Brunswick Drive, Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May late 8. 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) Jersey Shore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Jersey Shore, PA 21. Signature of Funeral Service 22. Name and Address of Facility RAM 4 DeVol Funeral Home, 10 East Deer Park Drive, Galthersburg, MD 20877 M01117 1 rules 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -cNa disease or condition resulting in death) Medical Due to (or as a consequence o **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician are for use as the burial-1 Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the i 1 Yes 2 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Voursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation etely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tile of certifie

Registrar DHMH 17 Rev 06-2011

State

30. Name and addre

31. Date filed (Month, Day,

Year

5 2012

s of person who completed cause of death (Item 23a) (Type, Print

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 2012 9 WILLIAM LOWE WILKINS 3:30  $\mathbf{P}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPICE CENTER OF QUEEN ANNE QUEEN ANNE'S CENTREVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min Director 214-42-8022 69 1 **X** M 2 □ F APRIL 6,1943 MARYLAND show 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD CAROLINE RIDGELY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral 11830 HOLLY ROAD 21660 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 1962-1965 other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SURVEYOR 12 CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ WARREN E. WILKINS RUTH A. LOWE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA A. WILKINS/WIFE 11830 HOLLY ROAD, RIDGELY, MD 21660 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of F. Important: If ite any injury or other Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MAY 15, 2012 STEVENSVILLE CEMETERY STEVENSVILLE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Retween Ohset and Death Immediate Cause (Final Physician/ PROSTATE CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of). resulting in death) Last the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Year 5 Other (specify) Month Pregnant at time of death g Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 2 HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural Accident 5 Pending To the Hospital or Attend within 24 hours after death To the Funeral Director: Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o 29d. Date signed (Month, Day, Year) 5/10/ 5 D006649 2012 719-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q.WILLIAM GAI WD 8221 TEAL DRIVE, EASTON, MARYLAND 21601

State Registrar rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:56 am Elsie S. Woolman May 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10401 Grosvenor Place. Rockville Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 056-09-7585 Director 1 🗆 M 2 🕇 F 97 June 18.1914 New York Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maruland 1 Tes 2 X No Montgomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be r Funeral 10401 Grosvenor Place, 20852 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. National Institutes Elementary/Secondary (0-12) College (1-4 or 5+) the should be filed with and Mental Hygien ? is marked other th Secretary of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Pollack Herman Storch other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 21759 Club Villa Terrace, Boca Raton, Florida 33433 Charlotte Weingarten/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State ō permit. Page 1 Department of Important: If ii any injury or o 1 X Burial 2 Cremation 3 Removal from State King David Mem. Grdns. ! 05/18/2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 71800 New Hampshire Ave., Silver Spring, MD 20904 ىق 23a. Part 1. Enter the dises shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ply one cause on each line. Immediate Cause (Final Onset and Death 15 Minutes Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) **Examiner** Arteriosclerotic Cardiovascular Disease 10 Years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No
9 Unknown Month the a Pregnant at time of death Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No thours after death.

uneral Director: Aftely filled in by the fur Accident Suicide Investigation 6 Could not be To the ...
within 24 hours after us
To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitio To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

State

Gary Fisher

31. Date filed (Month, Day, Year)

M.D.

1 0 201

person who completed cause of death (Item 23a) (Type, Print)

D13818

5530 Wisconsin Avenue, Suite 711, Chevy Chase, Maryland 20815

May 09. 2012

re regione 17083

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DAVID F. YOUNGER 2012 Medical 9:10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HEARTFIELDS ASSISTED LIVING **EASTON** TALBOT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 051-28-7781 1 **X** M 2 □ F 94 NEBRASKA SEPT.23,1917 28a-f show 10a. State 10b. Count er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director TALBOT **EASTON** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 700 PORT STREET 21601 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married \$ 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th DAIRY CATTLE HERDSMAN DAIRYMAN 6 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) FREDERICK M. YOUNGER THERESA KOPF 1 and 2 should b of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL Y. JOHNSON/ DAUGHTER 150 SONATA WAY, CENTREVILLE, MD 21617 Baltimore, 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State CHESAPEAKE CREMATION
CENTER MAY 11, 4 Donation 5 Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final onsest disease or condition years Medical resulting in death) Due to (or as a nsequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and-trar Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical that the death certificate be Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? for Month Day Pregnant at time of death Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? page 1 Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending within 24 hours after death

To the Funeral Director: /
completely filled in by the i Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated Certifying Nurse practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and litle of certifier 29d. Date signed (Month. Day, Year) 37064 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAMBERLAIN, M.D., 130 LOVE POINT ROAD, SUITE 107, STEVENSVILLE, MD 21666 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	arylan				and Ment	tal Hyg	iene		^ !
			Registrar  1. Decedent's Name (First, Middle	, Last)		Cen	tificate of L	Jeath	2. D	ate of Deat	leg. No.	3. Time of Death	<u>ე Ц</u>
يمذر	Physicia Medio	al	Franklin,	jale	4				14	alex	Day Y	1012 1217P	M
أمس	Examir	ier	4a, Facility Name (if not institution)	Give street and number) Mau (UNA	Medi	cal Cen	4b. City, Town, or	Location of	of Death	0	4c. County of	Death	
	Funeral Director		5. Social Security Number 215–30–8043	6. Sex	e (In yrs. Ia	st birthday)	If Under 1 Year Months Days	If Under Hours	Min. (A	ate of Birth Month, Day,	Year)	Birthplace (State or Fore Country)	ign
		L	Usual Residence of Decedent  10a. State  10b. County		77	Yrs.			Ju	ne 17	, 1934	Maryland	
	Marylan 8a-f sh tified a	Director	Maryland	Cecil	TOC. City	, TOWIT OF LOC		ort D	eposit			10d. Inside City Lim	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 194 Vineyard	Drive	-		10f. Zip Code	21904		1	I0g. Citizen of Wha	at Country?	
	death w	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S	13. W	as Decedent of Hi Yes, specify Cuba	spanic Orio	gin? (Specify Ye	es or No-	14. Race -	American Indian,	_
036	s after ral", or Examir	ed by	1 ☐ Never Married 2 ☐ Mar 3 🏞 Widowed 4 ☐ Divorced	ried 1 Yes 2 X	No		Yes 2 X No		, r deito filoan,	, 610.)	Specify:	White, etc. White	
21215-0036	72 hour n "natu fedical	Completed	(Specify only highe	nt's Education est grade completed)		(Give ki	ent's Usual Occupa nd of work done d		of working		16b. Kind of Busin	,	
212	within /giene. ner thai t, the N		Twelve Years	College (1-4 or 5-	+)		NOT use retired) oer Owner	r/Ope	rator			Barber Shop Maryland	
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, L Jame	es V. Yale	Yale 18. Mother's Name (F					, Middle, M	,		
ary	d 2 should be file alth and Mental H 27 is marked o er traumatic eve	- 59	19a. Informant's Name/Relations						r or Rural Rout	e Number,	City or Town, State	e, Zip Code)	
re,	1 and 2 f Health item 27 other to		Beverly Farmer 20a. Method of Disposition	: (Daughter	20b. PI	ace of Dispos	ineyard I		, Port		20c. Location - Ci	21904	
Baltimore, Maryland	permit. Page 1 Department of Important: If it any injury or o once.		1 Burial 2 X Cremation 4 Donation 5 Other (S		R.A	Ferri	atory or other place	inc.	05/07/	- 1	West Che Pennsylv	ester,	
Bal	permit Depar Impor any in		21. Signature of Funeral Service L	icensee	20 5	22. L	Name and Addres ee A. Pat erryville	s of Facility	on & So	n Fur	neral Hom	ne, P.A.	
ı			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused nly one cause on each line.	the death							Approximate Interval Between	
	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or us a	conseque	My page of	railure					Onset and Death	
	Examiner	r.	Sequentially list conditions,	b. Phe	un	mia	2						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events	Due to (or as a	conseque	ence of):							
	ite be executed hysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a	conseque	ence of):							
3760	e Se l	Medic	NE FEMALE:	d					-				
Box 68	that the death certificate ned by the attending physe detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	□ Fetal	death 3	Ectopic pregnancy Other <i>(specify)</i>	/			23d. Date o	•	
Ö.	the des	hysic	1  Yes 2 No 9 Unknown	g 🗌 Unknown							WORLD	Day real	
	0 0 0	<u>ا ک</u>	Part II. Other significant conditio	ns contributing to death bu	t not resu	Iting in the und	derlying cause give	en in Part I.	2:		acco use contribu s 2 🗆 No 3 [	te to the cause of death?	wn
Records,	has be ge 2 sho	Completed							2	4a. Was an autopsy	y prio	e autopsy findings available r to completion of cause o	
<u>.</u>	rtificate		25. Was case referred to medical examiner?	1			26. Pla	ce of Death	1 (Check only	Yes 2		Yes 2 No	50
† Vital	this ce	၉	1 Yes 2 No	Hospital:  1 Hopatier  28a. Date of injury		R/Outpatient 28b. Time of		4 ∟ Nur			nce 6 🗆 Other (S	Specify)	
o uo	anding sath. or: After he fune	Certificate:	1 Natural 5 Pending	g (Month, Day, ation		injury	28c. Injury work? M 1 🗆 \			escribe hov	v injury occurred		
Division of	after de Directo		3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		y - At hon (Specify)	ne, farm, stree	t, factory, office			cation (Stre ty or Town,		r Rural Route Number,	$\neg$
	to ure nogration or supplied in the law within 24 hours after death.  To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2:	edical	(Check 21 Medical E	Physician: To the best of m xaminer: On the basis of exa	amination :	and/or investia	ation, in my opinior	death occ	urred at the tim	e, date and	place, and due to	the cause(s) and manner sta	ated
F	within 2  To the comple	Σ	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practitioner: To the	best of my	knowledge, d	eath occurred at the	e time, date	and place, and	d due to the	cause(s) and manr	ner as stated.	nou.
			Talade	Talley			15586	860	06	1	Tay 44	2012	
	1		30. Name and address of person w	ho completed cause of dea	ath (Item 2	10 50	fot Bo	thin	none.	41)	2/2/2		
	State Registra	-	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu	re A A	artel		1				$\dashv$
	5,000		MAI 1	U MATE THANK	مهارس	1. 1	3-17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Physician/ Month ZIMMERMAN CAHILL 4:10 AM 8 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 20501 Goshen Road Gaithersburg Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 578-36-5424 88 **Director** 1 □ M 2 🗓 K June 16,1923 Washington D.C. 28a-f show 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20879 United States 20501 Goshen Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 💢 No Specify. White Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) School Teacher Catholic Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Irene O'Connor Francis P. Cahill should I and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8900 Emory Grove Road, Gaithersburg, MD 20877 Paul F. Zimmerman Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) Silver Spring, MD Gate of Heaven Cem. 21. Signature of Funeyal Service License 22. Name and Address of Facility DeVol Funeral Home (M01116) 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 6 Months Ph. sician/ Squamous Cell Maxillofacial Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examir Talensit Talensit Cause (Disease or injury that initiated events and Due to (or as a consequence of). resulting in death) Last attending physician the bur Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as 1 E FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No signed by the atter d be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 X No 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA ျ 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number May 9, 2012 D34386 10

State Registrar 9715 Medical Center Dr. #501

Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Carolyn B. O'Connor M.D.

31. Date filed (Month, Day, Year)

			Please	Type or Print in B		•	_	
			For	State of Maryland		Health and Mental H	lygiene	0 17000
			1 - State Registrar		Certificate of I	Death	Reg. No. 20	2 1/086
	Physicia Medic		1. Decedent's Name (First, Middle, Last	Winona	Brown	2. Date of Month	Death Day 20 Year	3. Time of Death
	Examir	ner	4a. Facility Name (it not institution, give	street and number)	4b. Gity, Town, o	r Location of Death	4c. County of Deal	th
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last		If Under 24 Hrs. 8. Date of		thplace (State or Foreign
	Director			M2 SF	Yrs. Months Days		1 - 11	buntry)
	nd how at	٦	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	10118	7 11950 IV	10d Inside City Limits
	faryla 8a-f s tiffied	ect	IN dM	A	Baltina			1 ✓ Yes 2 ☐ No
	the Na or 2	٥	10e. Street and Number	./.	10f. Zip Code		10g. Citizen of What Co	ountry?
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	4800 Yellowy		17 2	1209	I US	; <u>A</u>
(0	or iter	by Fu	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.)	lo- 14. Race - Ame Black, White	
21215-0036	rs afte ural",	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2 ♠ No	Specify:	Specify: P	lack.
5-0	2 hou "natu edical	Completed	15. Decedent's Ed (Specify only highest grad		16a. Decedent's Usual Occup (Give kind of work done)		16b. Kind of Business	/Industry
121	ithin 7 ene. • than	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NOT use retired)		QL, L. I	Maryland
	filed within all Hygiene. dother than event, the five files.	Be	17. Father's Name (First, Middle, Last)	O	Cient	18. Mother's Name (First, Midd	lle, Maiden Surname)	Ivaryland
/lan	d be f Venta arked itic ev	10	Carter	Brown		Rosa	Brows	\
Maryland	should be file and Mental H 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailing Address (Street	and Number or Rural Route Num	ber, City or Town, State, Zi	p Code)
	and 2 s Health tem 27		20a. Method of Disposition	Brown	812 Cari	VII Street		ND 21230
nor	Page 1 nent of I ant: If it		1 Burial 2 Cremation 3	Removal from State	ce of Disposition (Name of netery, crematory or other place	Date	20c. Location - City or	
Baltimore,	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Ligense		9 Memorial Cor	K 5/25/12	VVOUdlac	in Mo
ñ	permii Depar Impor any in		Fatelle 4. 1	Lairie & M.	2232 W	North Ave	Bouton P	MD 21216
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the death. I				Approximate Interval Between
~[	Physician/		Immediate Cause (Final disease or condition	Hyperterran	e cardiova	ascular di	seave	Onset and Death
Served.	Medical Examiner		resulting in death)	Due to (or as a consequen				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a consequen	ice of):			
	uted id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
	be executed sician and burial-transit	al Ex	resulting in death) Last	Due to (or as a consequen	ice of):			
09,	ate be physicia the bu		•	d				
Box 68760	ding parents	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnance	V		004 Data 444	B
30X	eath c atter d for u	icia	in the past 12 months?  1  Yes 2  No	4 Pregnant at time of dea	eath 3  Ectopic pregnand th 5 Other (specify)	у	23d. Date of de Month	Day Year
P.O. E	that the death certificate to led by the attending phys a detached for use as the	Physician/Medic	9 Unknown	9 Unknown				
σ.	been signed k	ρ	Part II. Other significant conditions con	ntributing to death but not resulti	lng in the underlying cause give Lailure 1	10000	d tobacco use contribute to ☐ Yes 2 ☐ No 3 ☐ P	
	been	Completed		10001	0 /a			
	oi €	dwc				ne	topsy prior to death?	ntopsy findings available completion of cause of
al	iciar certificate has rector, page 2	ا به ا	25. Was case referred to medical		26. Pla	1 ☐ Yeace of Death (Check only one)	s 2 No 1 Yes	s 2 No
Κİ	hysici nis cer il direc	To B	examine? 1 Ves 2 No	ospital: 1	Othe		sidence 6 Other (Spec	ify)
J Of	ling Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	8b. Time of 28c. Injury work	at 28d. Describ	e how injury occurred	
Sior	Atteno death ctor: / y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home		Yes 2 No	Ptroot and Alimbaras Di	rol Douto Alumban
Division of Vita	To the Hospital or Attending Physicial Within 24 hours after death. To the Funeral Director. After this certificate he completely filled in by the funeral director, page		4 Homicide determined	building, etc. (Specify)	s, farm, street, factory, office		(Street and Number or Rusown, State)	rai Houte Number,
	lospita t hours unera ely fille	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examin	cian: To the best of my knowledger: On the basis of examination ar	ge, death occurred at the time	, date and place, and due to the	cause(s) and manner as st	ated.
	the H	Me	only one) 3 L Certifying Nurse	Practitioner: To the best of my	rnowledge, death occurred at the	ne time, date and place, and due t	o the cause(s) and manner a	is stated.
	<b>6</b> ₹ 6 8		29b. Signature and little of certifier	, ur	29c. License	number	29d. Date signed (Month	ı, Day, Year)
	a)		30. Name and address of person who co	mpleted cause of death (Item 23	Sa) (Type, Print)	no My W	1 2/20/1	
<	3		Ranma	Solsham Ner	5 5101 La	mier Are	Baltimore	E MD 21215
	Stat Registra	e er	31. Date filed (Month, Day, Year) MAY 3 1 2012	32. Registry 's Signature	res		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen J. Blades  $201^{\text{Yea}}$ May 8:18 P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 17 Wallace Avenue Baltimore Anne Arundel Social Security Number 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 232 46 2257 **Director** 1 🗆 M 2 🕱 F West Virginia 79 09/09/1932 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Anne Arundel Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be 23a Funeral items 23 17 Wallace Avenue 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Denton should be Ida (not available) Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Blades / Son 17 Wallace Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4 Donation 5 Other (Specify) 05/31/2012 Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, it implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ORONARY ARTERY DISEASE 34RS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Exam Cause (Disease or injury for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): nding physician P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Tetal in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Year signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, METASTATIC BREAST CANCER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed after death.

Director: After this certificate 2 No Yes 2 XN 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 2 Accident 5 Pending iniury Investigation 1 Yes 2 No 2 ☐ Acciden 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) D0054739 29th 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 SVITE 204, GLENBURNIE UAIGWOOD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Buikstra Jan 30° 2012 11:00 PM May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Woodlands Assisted Living Middle River Baltimore 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 1**X** M 2 □ F 216-32-8148 March 14,1926 86 Holland 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2X No Edgemere Baltimore MD ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral United States 2407 Headland Blvd. 21219 death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Examiner Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2X No 1 Yes 2 XNo Specify: If Yes, Give "natural", Specify 3 ▼ Widowed 4 □ Divorced White Completed Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore Gas Elementary/Secondary (0-12) College (1-4 or 5+) Electric Co. 7 Years Meter Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ೭ Aukje Enaneme Frans Buikstra 19a. Informant's Name/Relationship (Type, Print) Sister In 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Phyllis Dumbrowsky Edgemere, Maryland 2407 Headland Blvd. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sacred Ht. of Jesus Cem.6/2/2012 Dundalk, Maryland 4 Donation 5 Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear the disease, or complications that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NON SMALL CITUL disease or condition CUNG MONTH Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 2 No Division of Vital ssisted 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Living 1 🗌 Yes ပ ER/Outpatient 3 DOA 1 Inpatient 2 I ☐ Nursing Home 5 ☐ Residence 6 Other (Spe 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation Director: 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-201

State

D0058475

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2012

PHYSTUDAN

PHZ CZP HZCATPUNZN 9114 PHZCADRCPHJA READ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Theresa E. Bason **Physician** 415 AM 5 29 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITal Rosedale Baltimore FRANKLIN SQUARE 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July26, 1921 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 □ XF 215-18-7766 90 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f sho event, the Medical Evaninar must be neathed at 1 ☐ Yes 2X No MD Baltimore Nottingham Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 USA 4002 Silver Spring Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home f Health and Mental Hygier tem 27 is marked other th other traumatic event, the 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry J. Horn Margaret Massong ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Darlene Kounelis /daughter 3228 Suffolk Lane Fallston MD 21047 permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr. once. timore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 5/30/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature) of Funeral Service Licensee aluh Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Edema **Physician** Pulmonary /Medical Due to (or as a consequence of): requira itation Examiner Severe mitral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examine severe mainutrition Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death.

I Director: After die die by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar ddress of person who completed & use of death (Item 23a) (Type, Print)

E-Sanual - Cuespo 9000 F

DOUG7697

9000 FRANKLIN Square DR Balto md

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#4a, 26perPHYS, G928, 674/2012, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 StateRegistrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JURNUM MAY 1141 2 2012 11.39 A Medical 4a. Facility Name (if not institution, give street
3 MIDDLE RIVER Examiner 4b. City, Town, or Location of Death 4c. County of Death MIDDLE RIVER BALTIMORE Social Security Number **Funeral** 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 - 20 - 1932 9. Birthplace (State or Foreign Months **Director** 213-30-8742 1 M 2 F 79 ILLINOIS Yrs sidence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits than "natural", or items 23a or 28a-fs he Medical Examiner must be notified MD BALTIMORE MIDDLE RIVER 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 MIDDLE RIVER COURT 21220 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ and 2 should be filed within 72 hours after or Health and Mental Hygiene. 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Completed 3℃ Widowed 4 □ Divorced Specify Year or Dates WHITE traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 THEODORE TURNEY MABEL CLARK 19a. Informant's Name/Relationship (Type, Print Rural Route Number, City or Town, State, Zip Code RISING SUN, MD 21! 19b. Mailing Address (Street and Number 103 AYERS DRIVE ROBIN KING/DAUGHTER 21911 injury or other 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1  $\square$  Burial 2  $\mathbf{X}$  Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 5-30-2012 CATONSVILLE, 21. Signature of Funeral Service Licenses once. 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ DN disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 nding pl IF FEMALE: 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d. Date of delivery for in the past 12 months?

1 Yes 2 No
9 Unkniwn Month Pregnant at time of death Day Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be a Records, 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 performed 22 No Yes 2 1 Tes or Attending Physician: **Division of Vital** 25. Was case referred to rpedica 26. Place of Death (Check only one) Companion's Hospital ٥ 1 Tyes 2 12 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Aesidence 6 Other (Specify House funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? within 24 hours after death. To the Funeral Director; After 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m 981 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box MILL MD 21117 IASNEEM mi) 0 1525 WINGS 32. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Physician/ Svoluer rma Month 955 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Dea ruch Musica Rihal Crownswille fund. Hrundy 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-4-1922 . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-16-9121 1 M 2 W Days Min 89rs. MARYLAND **Director** Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location be notified at 10d. Inside City Limits Director NOTTINGHAM BALTIMORE MD 28a-f 1 ☐ Yes 2X No 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21236 4102 TAYLOR AVENUE U.S.A. items 23 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ò Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 filed within 72 hours after WHITE 1 Yes 2 No Specify: "natural" 3 XWidowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Mec Elementary/Seconday (0-12) life. DO NOT use retired College (1-4 or 5+) HOMEMAKER OWN HOME 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SOPHIE VIEMEYER nd Mental F ANDREW DOELLE ည Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and is m 19a. Informant's Name/Relationship (Type, Print) Health a SANDRA BROMER/DAUGHTER JESSUP, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1X Burial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 5-31-12 PARKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebral Vasuler Immediate Cause (Final Atherosableron 2 Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to for as a consequence on Due to (or as a consequence of): physician Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed' this certificate ! 2 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ▼ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Hospital or Attending P 24 hours after death. Funeral Director: After the Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending М 1 Tyes 2 🗌 No 2 Accider
3 Suicide Accident Investigation the 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and of certifie CRU 40431 30. Name and address of person who completed car eath (Item 23a) (Type, Print) 0 6934 Blud Tation Sunte State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ ARTIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Days 209 12 8081 (Month, Day, Year) 02/10/1924 NEW JERSEY 88 Director 1 🖾 M 2 🗆 F Usual Residence of Decedent ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NOTTINGHAM BALTIMORE 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8346 CYPRESS MILL ROAD 21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married \$ 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) MASTER SGT. MILITARY Be Should be file.
I and Mental H
Is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PAUL BILY SR. MARGARET TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau SENDY ROMMEL / 45 ODEON CT. BALTIMORE, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State METRO CREMATORY 05/24/12 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Eur vice Lensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME CHESACO AVE BALTIMORE, 1211 MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC LUNG disease or condition resulting in death) MONTH Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, ANEMIA 1 Yes 2 No 3 Probably 4 Unknown DRONARY ARTERY DISPASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes ☐ Yes 2 ☐ No 25. Was case referred to ical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Sc ျ 1 Yes 2 □ No HOSPICE 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Many of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 31. Date led (Month, Day, Year State 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Demetra Cargas 2012 5:00 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Hammonds Lane Baltimore Anne Arundel . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign County) Maryland 8. Date of Birth **Funeral** 1 - M 2 X F Days 217 30 3736 79 **Director** 10/24/1932 Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severn 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 906 Merriweather Way 21144 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 🗓 Never Married 2 🗆 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Administrative Assistant Balto. Gas & Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o Gus Cargas Nellie Apostolos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Merriweather Way Maria Euzent / Niece Severn, Maryland 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Greek Orthodox Cem. |05/26/2012 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Chronic Obstration disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypalenin, Renal Insufficing Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The bours after death.
Funeral Director After this certificate held filled in by the funeral director, page 1 Ves 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and the second of the se

within 2 hours a pe eldmos

Registrar

V

Un Ellem

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of Pertifier

1) 30555

Min 24, 2002

Balk. MD 21230

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

0108 AM

VLANC

Yes 2 No

Approximate Interval Between Onset and Death

Day

Year

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ADELA A. NAVARRO

Adela A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 301 GRUEHN BLDG 3001 SHANOVEY St. Balto 170 82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland		ent of F ate of E			/ 11	2 17095
			Registrar  1. Decedent's Name (First, Middle, Last)	Certific	ale or L	<i>Death</i>	2. Date of Dea	Reg. No.	3. Time of Death
н	Physicia Medic		RONALD DENNIS COOK				MAY MAY	27, 20 <sup>T</sup>	
- Same	Examin		4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of I	
			SOUTHERN MARYLAND HOSPITAL  5. Social Security Number   6. Sex   7. Age (In yrs. last		CLINTO	N If Under 24 Hrs.	8. Date of Birt		GEORGE S
	Funeral Director		231-04-2934 1 X M 2 □ F 51	Mon		Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country)
	d wo		Usual Residence of Decedent	Town or Location			APRIL .	12,1961	VIRGINIA
	arylan a-f sh fied a	뜅	, , , , , , , , , , , , , , , , , , , ,	N HILL					10d. Inside City Limits 1 X Yes 2 □ No
	the Ma or 28; e noti		10e. Street and Number		. Zip Code			10g. Citizen of Wha	
	with with s 23a ust b	Funeral	1824 JARVIS AVENUE		20745			UNITED S	STATES
	death r item iner m		11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?	13. Was De If Yes,	ecedent of Hi specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
920	s after al", o Exam	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1 □ Y€	es 2 🏋 No	Specify:		Specify: I	' and the second of the second
5-0	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed		16a. Decedent's l		ation during most of work	ina	16b. Kind of Busin	
121	within 72 giene. Ier than '	Com	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT	use retired)	-		DDTI	A TUTE
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/lan	d be filed Mental Hy arked oth	မှ	GESFORD COOK			ERTHA	L.	GREEN	1
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		1	_				r, City or Town, State	
e, N	and 2 s Health tem 27		RINEICE N. KIRKLAND / DAUGHTER 3	3500 14T		ET #113,			
nor	age 1 ent of nt: If it y or o		1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State	RDALE CR	or other plac		Date / 2012	20c. Location - Cit	E, MARYLAND
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee						HOME, INC.
<u>m</u>	De E E		Naphney N. Cornelius	7474	LANDO	VER ROAD	, HYATTS	SVILLE, MA	ARYLAND 20785
			23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.						Approximate Interval Between
~	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	IMMUN	ODEA	ICIENC	4 Syn	DROME	Onset and Death
	Examiner		Human			CLENCY			
	<u> </u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequen		,				
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Box 68760	ificate ig phy as the		IF FEMALE:						
9 ×	th cert trendir or use	ian/I	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Birth 2 Fetal do	leath 3 🗌 Ecto		у		23d. Date o	
	ne dea	Physician/M	1  Yes 2 No 4 Pregnant at time of dea 9 Unknown	ath 5 ∐ Othe	er (specify)			Month	Day Year
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	by Pr	Part II. Other significant conditions contributing to death but not resulti	ing in the underly	ing cause giv	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
ds,	quires en sigi ould b			~~			1 🗆	Yes 2□No 3[	Probably 4 Unknown
COL	S S S	Completed				<u>.</u>	24a. Was	osy prio	e autopsy findings available r to completion of cause of
Re	Physician: The law r r this certificate has b aral director, page 2 s						perfo	rmed? dea 2 No 1	th? Yes 2 No
/ital	sician certif lirecto	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1  Inpatient 2  ER	2/0	Tothe	ace of Death (Chec			
of/	ig Phy cer this neral c		27. Manner of Death 28a. Date of injury 28	3b. Time of injury	28c. Injury	/ at		dence 6 Other (S now injury occurred	Бресіту)
on	tendin eath. or: Afi the fu	ifica	1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	M	work 1 🗆	Yes 2 No			
ivis	or Att	Certificate:	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fac	ctory, office		28f. Location (5 City or Tow		r Rural Route Number,
Ω	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge	ge, death occurre	ed at the time	e, date and place, a	and due to the ca	ause(s) and manner	as stated.
	the Ho iin 24 I the Fu	Medical	(Check 2 Medical Examiner; On the basis of examination are only one) 3 Certifying Nurse Practitioner: To the best of my l	nd/or investigation	n, in my opinic	on, death occurred a	at the time, date a	ind place, and due to	the cause(s) and manner stated.
	To the within 2		29b. Signature and title of certifier		29c. License	number		29d. Date signed (N	fonth, Day, Year)
	1		00 November 1970 2	20/75: 51:	DO 7	+1421		5/28/	12
	4		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23)  THY O EHIABOR, MD  31. Date filled (Month, Sep Year)  32. Registrar's Signature	SouTHE	RN MI	HRYLAND	HOSPITAL		
	Stat		31. Date (lee (Month, 20 (ar))	Kel		, , , , ,	, - gr e reg		
	Registra	ar	HILL O & TALL MONTH OF THE PARTY						

amend #14 per fh. g928 6-5-12 sm
Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 26 per doc g927 5-31-12 vt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Helen Elizabeth Close 2012 Medical 05 10:00a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Magnolia Manor Assisted Living Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 - M 2/- F Min. Director 80 577-42-5604 04 1 32 ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Catonsville MD Baltimore 1 🗌 Yes 2 💢 No 10e. Street and Number 10q. Citizen of What Country? "natural", or items 23a Funeral 900 South Rolling Road 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. White þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade <u>Private Homes</u> <u>Housekeeper</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edward Maske Nellie Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Williams-Daughter Crucible Ct., Millersville, Md 21108 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) On-Site 4 Donation 5 Other (Specify) 5/30/2012 Baltimore, Md 21. Signature of 22. Name and Address of Facility March F/H West 4300 Wabash Av 21215 Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ END CHAGE 1152002 MILLIHE More disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by といけいの トリナナーショの CHHONIZ 1 ☐ Yes 2 🎔 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? LISLASE BIHOLOR 24a. Was an performed? Yes 2 2 No 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Assisted Other: 1 🗆 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Living 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Funeral Director: Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one . Signature a 29d. Date signed (Month, Dav. Year) Mese 29/2012 D30408 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russ mineron my THE WASHINGTON and Rowh RATIMEN 31. Date filed (Month, Day, Year) 32. Proistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Medical Charles Clary Jr. 05 201 9:45p. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey
Social Security Number 18 <u>Baltimore</u> 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth Days Hours (Month, Day, Year) 213-36-3457 Director 1 X M 2 □ F 06 16 70 41 MD i Hygiene. other then "neturel", or items 23e or 28e-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Randallstown 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21133 U.S.A. 15 Auentura Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2th grade Shop Steward National Gypseum e 1 end 2 should be filed wit of Heelth end Mentel Hygle If item 27 is merked other ir other treumetic event, III Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Margarite</u> Willis <u>Charles Clary Sr</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Clary-Wife
20a. Method of Disposition Auentura Ct., Randallstown, Md 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 e Depertment of H Importent: If ite eny injury or ot Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/1/2012 Druid Ridge Pikesville, Md 21. Signature of Funeral Service License BR 22. Name and Address of Eacility March F/H West Tal 4300 Wa<u>bash Ave</u>, Baltimore Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 Immediate Cause (Final Physician/ CARCINONIA OF 4 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): nding physiclen end use es the buriel-trensli Cause Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical deeth certificete be Division of Vital Records, P.O. Box 68760 IF FEMALE: ettending for use e yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death cate hes been signed by the capes 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes 1 🗌 Yes To the Hospitel or Attending Physicien: within 24 hours efter deeth.

To the Funerel Director: After this certific completely filled in by the funerel director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other:
4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPILE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitione To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 828 No MARCEZ 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

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		Registrar  1. Decedent's Name (Fi				Oeri	meate or i	Death	2. Date of D			Time of Death
	dical	LEO	WARRE		CHAME	BERS			Month 5	2 Pay	<u> </u>	2:00 PM
Exam	71	4a. Facility Name (if not Frank)  5. Social Security Numb	in Sa	yare			4b. City, Town, o	If Under 24 h		Ba	ty of Death	State or Foreign
Direct		215-68-49 Usual Residence of De	942	M 2 🗆 F		7 Yrs.	Months Days		lin. (Month, D	Day, Year) 1 – 1954	Country) MARYI	
Maryland 28a-f sho otified at	Funeral Director	MD	b. County BALTI	MORE	10c. City	, Town or Loc		EDALE			1	nside City Limits
h with the ns 23a or nust be r	neral D	10e. Street and Number 8010 DUV		NUE			L	21237		1	f What Country?	
ire, Maryland 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  If mar 2? is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 🛴 Never Married  3 🗌 Widowed 4 🗆	2  Married Divorced	<ol> <li>Was Deceden Armed Forces</li> <li>1 ☐ Yes 2 [ If Yes, Give Year or Dates.</li> </ol>	?		as Decedent of H Yes, specify Cuba ☐ Yes 2X No		(Specify Yes or No erto Rican, etc.)	"	ace - American in ack, White, etc. fy: WHITE	
1215-(hin 72 ho ne. than "nat	Completed by	(Specify Elementary/Seconda 12	5. Decedent's Educ only highest grade ary (0-12)	cation completed) College (1-4 o	r 5+)	(Give ki life. DO	nt's Usual Occup nd of work done NOT use retired)	during most of v	working		Business/Industry	
Maryland 21215-0036 2 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	To Be C	17. Father's Name (First, DONALD		S (	CHAMB		SSEMBLY	·	Name (First, Middle	e, Maiden Sumar	RAL MOT ne) GHAM	ORS
e, Mary and 2 should Health and N tem 27 is ma	П	19a. Informant's Name/ CARROL CI			R		Address (Street		Rural Route Numb	er, City or Town, EDALE ,		237
0 0 = -		20a. Method of Disposit  1 🔀 Burial 2 🗆 C 4 🗆 Donation 5	Premation 3 R	emoval from Sta	ce ce	ace of Dispos metery, crema	ition (Name of atory or other plac OF FAIT	<sup>се)</sup>	Date 2-2012		- City or Town, S	
Baltimo permit. Page Department Important: I	ouce.	21. Signature of Funeral		> 1	文	22.		ss of Facility (	CVACH/RO	1	E FUNER	
Physicial Medic Examin	al	23a. Part 1. Enter the d shock, or heart fail Immediate Cause (Fina disease or condition resulting in death)	lure. List only one	Sep	ed the death ne. SiS s a conseque		the mode of dyin	g, such as card	liac or respiratory a	arrest,	Inter	roximate rval Between et and Death
e be executed ysician and le burial-transit	lical Examiner	Sequentially list conditi if any, leading to immed cause. Enter Underlying Cause (Disease or injur that initiated events resulting in death) Last	y S c.		s a conseque							
20. Box 68760 at the death certificate be of by the attending physic detached for use as the bh	Physician/Medical	IF FEMALE: 23b. Was decedent pregin the past 12 mont 1  Yes 2 Nog Unknown	ths?	c. If yes, outcom  1  Live Birth  4  Pregnant  9  Unknowr	2 Fetal at time of de	death 3	Ectopic pregnand Other (specify)	су			ate of delivery lonth Day	Year
و ت 🛨 🗖	ğ	Part II. Other significan	nt conditions cont	ributing to death	but not resu	Iting in the un	derlying cause gi	ven in Part I.			tribute to the cau	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ris after death.  al Director: After this cartificate has been signed by the led in by the funeral director, page 2 should be detach	Completed									opsy formed?	Were autopsy fir prior to complet death?	ion of cause of
Vital Resident The certificate lirector, pag	Be	25. Was case referred to examiner?  1  Yes 2 No	/  -	spital:			Oth	ace of Death (C				
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	cate: To	27. Manner of Death	Pending Investigation	28a. Date of in (Month, D	jury 2	R/Outpatient 28b. Time of injury	28c. Injury	4 ∐ Nursin y at	g Home 5 Res 28d. Describe	idence 6 L Ot how injury occur		
To the Hospital or Attent within 24 hours after death. To the Funeral Director: completely filled in by the	Certificate:		Could not be determined	28e. Place of Ir building, e	ijury - At hon tc. (Specify)	ne, farm, stree	t, factory, office		28f. Location ( City or To	(Street and Numi wn, State)	ber or Rural Route	e Number,
e Hospita 124 hours e Funeral	Medical	(Check 2 ∐ I	Certifying Physici Medical Examine Certifying Nurse I	r: On the basis of	examination	and/or investig	ation, in my opinio	on, death occurre	ed at the time, date	and place, and d	ue to the cause(s)	and manner stated
To the within 2 To the comple	-	29b. Signature and title o					29c. License		1	29d. Date sign	ed (Month, Day, Y	'ear)
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	ate	30. Name and address of Shirt Value	len Pa	tel 90		ankli		ne Dr	ve Bal	timor	e,MD 6	11237
Regis	trar	MAY 3	1 2012	anun	A.	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 7:15 PM Eugene Francis Doerfler Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Regional Hospita Prince George Laure If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 395-26-6280 Director 1 **₹** M 2 □ F 80 Aug. 25, 1931 Wisconsin 28a-f show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ∍ms 23a or 28a-f sh r must be notified a Arlington 1XX Yes 2 No Arlington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1300 Army Navy Dr., Apt. 208 22202 USA items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. "natural", Specify: 3 Widowed 4x Divorced Completed white Year or Dates Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) DIFECTOR OF Real 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Estate Development Giant Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental f ris marked o ၉ Andrew Doerfler Helen Schlitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Leslie R. Doerfler/ Son 14531 Dowling Dr., Burtonsville, MD 20866 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May ∠o 2012 permit. Page 1
Department of Important: If it any injury or o once. ō 1 Burial 2XXCremation 3 Removal from State cemetery, crematory or other place West Arundel Crem. 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD ure of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01053 313 Talbott Ave., Laurel, MD 20707 P. 1. Enter the disease, or complications that shock, or heart failure. List only one cause on ea 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Stage Onset and Death III End Disease Ph\_sician Renal Medical Examiner teriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Diabetes Exam and -tran that initiated events resulting in death) Last Due to (or as a consequence of attending physician a I for use as the burial-Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform performed? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fir Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month. Dav. Year)

157 V

DHMH 17 Rev 06-2011

Registrar

Laurel

Bowie Road, Suite 208

30. Name and address of person who completed cause of death (Item 23a) (Type

Sadiq, M.D.

Syed

1. Date filed (Month, Day

MAY 3 1 2012

14333

			State of Maryland / De	epartment of Health and leartificate of Death	Mental Hygi	_	2 17100
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Shirley May Diamond		2. Date of Death Month	28, 2ŏ12	3. Time of Death 3:09 PM
	Examin	er	4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death		4c. County of Death	George's
	Funeral Director		5. Social Security Number 215-76-6678  Usual Residence of Decedent  6. Sex 1 □ M 2 ☒ F  7. Age (In yrs. last birthdi	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	'ear) Cou	nplace (State or Foreign ntry)  DC
	faryland 8a-f show tified at	ector	10a. State		<u> </u>		10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the N s 23a or 2 ust be no	Funeral Director	10e. Street and Number  15222 Dino Drive	10f. Zip Code 20866	1	)g. Citizen of What Cou	intry?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1  Yes 2 X Yo  If Yes, Give  Year or Dates.	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 XXIII Specify:		14. Race - Amer Black, White Specify: Whi	etc.
21215-0036	ithin 72 hou ene. r than "nati the Medica	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation ive kind of work done during most of work by DO NOT use retired)  er Worked	king	6b. Kind of Business/I	
Maryland 2	2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "rtraumatic event, the Med	To Be	17. Father's Name (First, Middle, Last) Thomas Robert Diamond	18. Mother's Nan	ne (First, Middle, Ma lizabeth	niden Surname)	abte
	1 and 2 shou of Health and item 27 is m other traum		Betty A. Webb/ Sister 920	ailing Address (Street and Number or Ru 4 Weant Dr., Great			Code)
Baltimore,	permit. Page 1 s Department of h Important: If ite any injury or ot once.		1 ☐ Burial 2 XXCremation 3 ☐ Removal from State cemetery, 4 ☐ Donation 5 ☐ Other (Specify) West Ar	undel Crem. 20	ne 1, )12	Oc. Location - City or 1	MD
Bal	Depar Impo		21. Signature of Funeral Service Licensee  M01053  23a. Fay 1. Enter the disease, or complications that caused the death. Do not	22. Name and Address of Facility Don 313 Talbott Ave.,	Laurel,	MD 20707	
	Physician/ Medical	0 D	str ck, or heart failure. List only one cause on each line.	ock	or respiratory arrest		Approximate Interval Between Onset and Death
1000	Examiner	ıer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):	hy			
	be executed sician and burial-transit	l Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Sepsis  Due to (or as a consequence of):				
3760	ificate be ig physicia as the bur	Medical	IF FEMALE:	piratory Failure	દ		
P.O. Box 6876	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
	requires that the despeen signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the Down Syndrome	ne underlying cause given in Part I.		cco use contribute to	the cause of death?
Division of Vital Records,	: The law re cate has be r, page 2 sh	Completed by			24a. Was an autopsy perform 1  Yes 2	prior to co	opsy findings available ompletion of cause of 2 No
ital	Physician: The this certificate aral director, pag	Be	25. Was case referred to medical examiner?   Hospital:   Hospital:   William   1   Milliam   2   FR/Output	26. Place of Death (Chec	k only one)		
on of V	nding Physath. : After this e funeral d	cate: To	1 Yes 2 No Inspired 1 Inpatient 2 ER/Outp.  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injured injures injures (Month, Day, Year)	e of 28c. Injury at	ome 5 Residen 28d. Describe how	ce 6 Other (Specifinjury occurred	ý)
Divisio	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospi within 24 hou To the Funer completely fi	Medical	29a. Certifier (Check children in the control of th	vestigation, in my opinion, death occurred a	at the time, date and	place, and due to the ca	ause(s) and manner stated.
	7 Witi		29b. Signature and title of certifier  A D	29c. License number  DE0 / 29		d. Date signed (Month, $5-28$	
5	IJ		30. Name and address of person who completed cause of death (Item 23a) (Typ Zorayda Lee-Llacer, M.D. Laur 31. Date (1917)	e, Print) Le Regional Hospi	tal Lau	5-28 o Van Dus irel, MD	en Road 20707
	Stat Registra		31. Date (14 1/03), Pay 2012 Level 32. Begisty & Signature				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per dr.,g928,06/14/2012dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Bonnie Marie Darmofall aka 2. Date of Death 3. Time of Death Physician/ O Bonnie Marie Darmafall 7-20A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore City 1125 Horners Lane Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) **Director** 244-24-0858 1 □ M 2 😾 F 89 Yrs Aug. 31,1922 Nebraska Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A MD 1X Yes 2 □ No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 United States 1125 Horners Lane 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Completed Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Maryland Cup Co. Line Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minnie Woody Long 19a. Informant's Name/Relationship (Type, Print) ${
m Daughter}$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Milinda D. Jensen HC 83 Box 35 VM Capon Bridge, West Virginia 26711 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Towson, Maryland Hilltop Service Corp. 5/29/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Scott P. Gardner 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Dundalk. Maryland 7922 Wise Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ANCE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it only leading to it mediate cause. Enter Underlying Examine Due to for each constitution of Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy 1 Yes 2 To Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28195 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Arthur Disney 2012 Frank May 28 10:03 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Co. Timonium Stella Maris Hospice Center 1 Year If Under 24 Hrs. . Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Director 220-01-5359 1 XM 2 F 22,1922 90 Jan. Maryland 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director Edgemere MD Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21219 United States 3228 Lynch Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. o þ 1 Never Married 2 X Married 1 XYes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates. WWII or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Steel Industry Material Leader 10 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fannie Dennis James W. Disney 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code, 3228 Lynch Road Edgemere, Maryland 21219 Health a Mrs. Irma Lee Disney (Wife) Baltimore, mportant: If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date þ 1 Burial 2 Cremation 3 Removal from State Moreland Mem. Park Cem. 6/1/2012 Baltimore, Maryland Other (Specify Entombrent 4 Donati Buda-RuckesFufferal Home of Dundalk, any 21222 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tra Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 attending ph IF FEMALE: FRANK DISNEY 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Pregnant at time of death Year ed by the a detached g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 performe Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After after death.

Jin by ++ X Natural 5 Pending work? 1 Yes 2 No Accident Investigation М Suicide 6 Could not be in 24 hous. the Funeral Directory filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of o 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of beath (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

State
Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav : 15 PM wrence Dot terweich Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner G000 Samantan HOSPITAL WHMORE, MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 212-32-4702 1 🕅 M 2 🗆 F Maryland 77 Feb 5, 1935 Usual Residence of Decede ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Timonium 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21093 USA 12030 Tralee Road, #302 be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. If Yes, Give Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Inspector Planner Steel and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mildred Marie Griffin permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Dotterweich, Sr. Martin Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12030 Tralee Road, #302, Timonium, MD 21093 Joan Dotterweich/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 05/30/2012 Glen Burnie, Maryland Signatire of Funeral Servin, License Bryan W. Clary Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. 5 fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart fullure. List only one cause on each line. Interval Between Onset and Death Immediate ause (Final Septic Physician/ disease or andition resulting in deal HOUVÝ Medical Due to (or as a consequence of): Examiner ancreasit Houri Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) for use as the burial-transi Cause (Disease or injury LICHEM that initiated events resulting in death) Last ding physician and Due to (or as a consequence of): distress syndrome) Physician/Medical res Diratory P.O. Box 68760 s, outcome of pregnancy Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) signed by the at id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Cholerystectomy, suprave Atricular 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an tachycandia autopsy performed? 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending injury work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of cert 29c. License number

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persol

5661 N. LOON ROVEN

Flunde Batimore, 32. Register's Signature MAY 3 1 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month George L. Dupski М 2012 4:55P Medical May 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1705 Cardinal Estate Lane Glen Burnie Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 219-32-2565 1 🛛 M 2 🗆 F March 28, 1936 Director 76 Maryland 28a-f show 10b. County aţ 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Anne Arundel 1 Yes 2 X No Glen Burnie ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a 1705 Cardinal Estate Lane 21061 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. "natural", Specify: White If Yes, Give Year or Dates. 154-156 Completed 3 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Security Officer Race Track Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) : should be file n and Mental I 7 is marked o ည Nicholas Dupski Josephine Miller 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Catherine Shaver : Sister 9134 Rockcliff Drive, Easton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Ardent Cremation, Inc. 5-30-12 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. metal P. 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Congestive Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): ig physician and as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month signed by the ar Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Kidney disease 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an has page 2 autopsy performed? Yes 2 X No certificate funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending s after death.

I Director: Af Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

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completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month. Day, Year) 5/29/2012 40 100637 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20116 MID - 450n 8601 Veturas Muy Lugenia 31. Date filed (Month, Day, Year) MAY 31 Registrar

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Funeral		5. Social Security Number	6. S		Age (In yrs. I	ast birthday)	If Und	er 1 Year	If Under	24 Hrs.	8. Date of Bi	irth	1	g. Birth	place (State o	or Foreign
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1036 rs after death rral", or item Examiner n	by Fu	<ol> <li>Marital Status</li> <li>Never Married 23</li> </ol>	₹Married	12. Was Decedent Armed Forces 1  Yes 2	?		Nas Dece f Yes, spe	edent of H ecify Cuba	ispanic Orig in, Mexican	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)	-		e - Amerio k, White,	can Indian, etc.	
215-0036 In 72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at	g [	3 Widowed 4 D		If Yes, Give Year or Dates		1	I ☐ Yes	2 <b>XX</b> No	Specify:				Specify:		White	
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Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.	ſ	21. Signature of Funeral Se	ervice Licens	see 9							rose Fu			-		
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Examiner	<u>,</u>	Sequentially list conditions	s,	b. ———										_		
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ng Ph ffer th uneral		27. Manner of Death 1 ☑ Natural 5 ☐	Pending	28a. Date of ir (Month, D	jury	28b. Time of injury		28c. Injury work	/ at		28d. Describe				7	
ttendideath death the f	<u>≅</u>	2 Accident	Investigation			<i>(</i>	М		Yes 2 🗌							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate to the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical Certificate:	4 ☐ Homicide	determined	28e. Place of li building,	etc. (Specify	me, ram, stre	et, racto	у, опісе			28f. Location ( City or To			r or Rura	i Route Numb	oer,
Hospi 24 hour Funera etely fill	edica	(Check 2 □ Me	dical Exam	sician: To the best iner: On the basis of	examination	n and/or invest	igation, ir	my opinio	n, death oc	curred at	the time, date	and place	e, and due	to the ca	use(s) and ma	nner stated.
To the within To the comple		only one) 3 ⊔ Ce 29b. Signature and title of		se Practitioner: To	tne best of r	ny knowledge,		curred at to c. License		e and pla	ce, and due to		se(s) and ma ate signed			
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\$	ļ	30. Name and address of p	erson who	completed cause of	death (Item	1 23a) (Type, P				_		/	1-	110		
		Thomas C 31. Date filed (Month Day)	hior	cp 1120	10-1	folling	, A	d V	3a14	inn	u, n	10	212	28		
State Registra		MAY 3 1 2	JTZ /	Zerra 32. Regis	S SIGN	W.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day PATRICIA DALE DAWSON 3:30a M 2012 MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2833 W. GARRISON AVE Social Security Number 6. Sex BALTIMORE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min 3-9-1956 VIRGINIA Director 56 217-70-0957 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits notified at 10c City Town or Location Director 1

Yes 2 □ No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö er than "natural", or items 23a or the Medical Examiner must be Funeral USA 21215 2833 W. GARRISON AVE. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 ₩Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) STATE OF MARYLAND HOMECARE PROVIDER should be filed with and Mental Hygien Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ CHRISTINE LOGAN GEORGE DAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar. Important: If item 27 is any injury or any 2833 W. GARRISON AVE. BALTIMORE, MARYLAND 21215 DENISE DAWSON(SISTER) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Cremation 3 Removal from State 5-31-2012 BALTIMORE, MARYLAND METRO CREMATORY D. HIBNER2. Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. JONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ NGESTIV disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine INFEC T and Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? BREAST CANCER 24a. Was an autopsy performed' BESIT cate | Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical After this certifi 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2  $\square$  No hours after death Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical

State Registrar 29a. Certifier (Check

29b. Signature and title of certifier

PATTE

MAY 3 1 2012

4120

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, dea

AVE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SON

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

urred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

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waune Evans	State of Maryland / Depa			ıl Hygiene	201	2 1710
Dii.i.	Registrar	rtificate of D	<u>eaur</u>	Re 2. Date of Death	g. No.	3. Time of Death
Physiciai ledical Examin				Month May 26, 20	Day Year	0200 hrs
	4a. Facility Name (if not institution, give street and number) University Hospital		City, Town, or Location of I saltimore		4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. I	_	f Under 1 Year If Under 2 Months Days Hours		h(MM/DD/YYYY) 9. Bir 5 / 1 9 8 5 Foreig Co	thplace (State or InMaryland
	Usual Residence of Decedent					
w any		Town or Location				10d. Inside City Limits  1 X Yes 2 No
Maryland 28a-f show	10e. Street and Number		of, Zip Code	110	og. Citizen of What Cou	
th the Maryland 23a or 28a-f sho	10e. Street and Number 3017 Elizabeth Avenue		21230		USA	
with t			ecedent of Hispanic Origin			can Indian, Black,
death	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 X No		specify Cuban, Mexican, P	uerto Rican, etc.)	White, etc.	
s after	Widowed 4 Divorced II 18s, Give 1eer or Dates:		s 2 X No specify:  Jsual Occupation (Give kin	d of work done	Specify:Blac	
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036 rithin 7 ane.	Elementary/Secondary (0-12)  College (1-4 or 5+)  12th grade	Studer				ani
	9 17. Father's Name (First, Middle, Last) Larkin Byrd			Name (First, Middle, M		
212 ald be Menta mark	Larkin Byrd  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Ad	dress (Street and Number			, Zip Code)
MD d 2 sho lth and n 27 is	Larkin Byrd/Father		Park Height			
ore, s l and of Heal of item	1 Y Burial 2 Cremation 3 Removal from State	crematory or other		Date 06/02/12	20c. Location - City or Landsdown	
Baltimore, oermit. Pages I an Oepartment of Hea Capartment of Hea Capartment: If itel injury or other tr	4 Donation 5 Other Specify:	.Zion Ce	INCCCT y			
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other fraum	21. Signature of Funeral Service Licensee	5240	e and Address of Facility (  Reisterst	Chatman-E cown Rd.E	Harris Fur Baltimore	neral Home MD.21215
Physician	23a. Part I. Enter the disease, or complications that caused the death failure, List only one cause on each line.	n. Do not enter the n	node of dying, such as care	diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease a. Gunshot Wounds (2) of	f Right Chest a	nd Left Buttock			Death
	or condition resulting in death)  Due to (or as a consequence of	of):				
	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of the conditions)	of);				
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or Due to (or	of):				
8 5 3	OI I INDENDED II AMENDED					
1876 tificate ng phy as the b	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of preg	gnancy 2 Fetal o	leath 3 Ectopic p	regnancy	23d. Date of delivery  Month	/ Day Year
Ox 68: ath certifi attending or use as	past 12 months?  4 Pregnant at time of de	ooth =	(Specify)			
tr the des	TF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  23c. If yes, outcome of pregnant at time of dearth but not reconstributing to death but not reconstributing	resulting in the unde	rlying cause given in Part	l, 23e. Did tol	bacco use contribute to	the cause of death?
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rds, requir			-	24a. Was a		topsy findings available completion of cause of
Reco The law icate has	Completed	-		perform	med? death?	
tal Rec	25. Was case referred to medical		26.Place of Death (C	heck only one)		
Physic Prysic er this	1 Yes 2 No 1 Inpatient 2 V	ER/Outpatient 3 28b. Time of Injur			Residence 6 Other	
ndiog Plub.	1 Natural 5 Pending May 26, 2012	0125 hrs	1 Yes 2 ✓ N	Subject shot		
/iSiC r Atte ter dea irecto	2 Accident Investigation 28e. Place of Injury - At h	nome, farm, street, fa	actory, office building, etc.		treet and Number or Ru	ral Route Number, City
Dipital o	4 V Homicide determined (Specify) Local Stree	et		or Town, St Fredmount Av	enue and Pitcher Ave	enue, Baltimore, MD
	293. Certified 1					
T Will	and manner stated.  29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo.	nth, Day, Year)
	D-~UL.		O.C.M.E.		May 27, 2012	
21	Name and address of person who completed cause of death (Item Donna M. Vincenti, MD Assistant Medical Exar		Baltimore Street B	altimore MD 211	223	
Sta		ure				
Registr	27 - 4 0010	1. park	<u></u>			
DHMH 17 Rev 1/200 OCME 2006	OCME	ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Terrie Elmore Ann 12:30 AM 30 May 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Howard Columbia, Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number g. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Feb. 8, 1966 Director 219-84-6542 46 Maryland Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location death with the Maryland notified at 10d. Inside City Limits Director 1 Tes 2 XXNo MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 432 Old Line Avenue 20724 U.S.A. items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married "natural", or Completed by Yes 2XXNo 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Maditione. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Grade 12 College (1-4 or 5+) Office Manager G&K Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Allen Bowen Alice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip A. Elmore / spouse 432 Old Line Avenue Laurel, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Lone Star Cemetery 4 Donation 5 Other (Specify) 6/2/2012 Covington, VA Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Non Small Cell disease or condition resulting in death) months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year g Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be Cancer Esophageal 2 No 3 Probably 4 Unknown Leg Deep Vein Thrombosis 24b. Were autopsy findings available 24a. Was an certificate has prior to completion of cause of death?

1 Yes 2 No autopsy director, page 2 Crohuis disease Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May, 30, 2012 MD \_ Intensivist D0062273 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard County General Hospital 5755 Cedar Lane, Columbia, MP 21044 Shahriar Amin, MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) MAY 3 1 2012

32. Registrar's Signature

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			1	For State	State of Ma	aryıan			or Hearth a of Death	and ivi		_	201	2 17100
			1	Registrar  I. Decedent's Name (First, Middle, Las	t)		Cei	incate (	Death		2. Date of Dea	Reg. No	201	3. Time of Death A
П	Physic Med		L		ERHART						Month	2F	Year	3. Time of Death
	Exam	iner	4	a. Facility Name (if not institution, give 1210 Quantril				4b. City, Tow Balti	vn, or Location o _more	of Death		4c.	County of Dea	th D
ı	Funera Directo		2	213-52-1529	7. Age	e (In yrs. la	nast birthday) Yrs.	If Under 1 Months D	ear If Under 2 ays Hours		8. Date of Birt <i>(Month, D</i> ay 0 6 / 0 2 /	h 1 <sup>ear)</sup> 5	9. Bir Co Ma 1	thplace (State or Foreign ountry) cyland
	and Show	٦	_	Jsual Residence of Decedent  0a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Maryli 28a-f	Director	M	Maryland		Balt	timore							1 🔀 Yes 2 □ No
	with the s 23a or ust be r	Funeral D		Oe. Street and Number 1210 Quantril V	Way			10f. Zip Co				10g. Cit	izen of What Co }	ountry?
9800	e filed within 72 hours after death with the Maryland tral Hygiene. at other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	à	1	1. Marital Status 1  Never Married 2  Married 3  Widowed 4  Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.		l1	Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.)     □ Yes 2 □ No Specify:					14. Race - Ame Black, Whit SpecifyWhi	e, etc.
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212	within giene. ier tha			7th grade	College (1-4 or 5-	+)		Mana Mana	*					ce Store
Baltimore, Maryland 21215-0036	uld be filed Mental Hy narked oth	To Be	L	7. Father's Name (First, Middle, Last) Dores Wagner					1		First, Middle, Leary	Maiden Surname)		
Mar	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en			19a. Informant's Name/Relationship (Ty.) Angelita E. Vazo			1	-	reet and Number tril W			-		
ore,			_	0a. Method of Disposition 1   Burial 2 □ Cremation 3 □		0	Place of Dispo	sition (Name on natory or other	place) 0	5/3 <sup>h</sup>	ate/ 201 2	20c. Lo	ocation - City or	
altin	mit. Page partmer portant / injury		2	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licence	<i>i)</i> ee	Mea			em . Par					neral Home
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. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF 23	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Feta	death 3	3  Ectopic pregnancy 5  Other (specify)					23 <b>d</b> . Date of de Month	livery Day Year
Division of Vital Records, P.O.	quires that then signed by wild be detact	þ		Part II. Other significant conditions co	intributing to death bu	ut not resi	ulting in the u	nderlying caus	se given in Part I.					o the cause of death?
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ivisio	l or Atten after deat Director: I in by the	Certificate:		2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined						-	3f. Location (S City or Town			ral Route Number,
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		ate	31	1. Date filed (Month, Day, Year)  MAY 3 1 20	DEC MD He 32. Egistrar	c's Signat	ure	rus to	> Digit	Ki.	IKIVE (	115	HIEDIL	121/21090
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Fisher 12:07 PM 05 2012 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** VA Medical Center Baltimore Baltimore If Under 24 Hrs. 5. Social Security Number 6 Sex Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 214-50-4806 63 Director 1 **X** M 2 □ F 2/18/1948 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10b County 10c. City, Town or Location Director notified Maryland Baltimore Pikesville 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a or be 1 Funeral 4209 Lowell Drive 21208 USA event, the Medical Examiner must 'natural", or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc Yes 2 No f Yes, Give by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Md . of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me State Envirormental Elementary/Secondary (0-12) College (1-4 or 5+) Welder Services 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Fisher Sr. Ida Mae Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4209 Lowell Drive Pikesville MD.21208 Department of Health Important: If item 27 Michelle Fisher/Wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cemetery 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Owings Mills,MD. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home anyi 5240 Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Hepato cellu Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the IF FEMALE: nse yes, outcome of pregnancy

Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day for Month Year Pregnant at time of death Yes 2 No signed by the a ld be detached l 1 | Yes 2 | g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 : autopsy performe Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 2 🛮 No 1 🗌 Yes ပ 1 🗹 Inpatient 2 🗀 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Aformpletely filled in by the fu М Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2, To the F complet 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 05/27/2012 Tau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Baltimore, MD MD 10 N Greene 31. Date filed (Month, Day, distrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May <sup>Day</sup> 2012 Brian James Geise 9:07A 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 625 Lucabaugh Mill Rd. Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours (Month, Day, Year) 214-02-1964 Director 46 1 XM 2 | F 7-10-1965 MD Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 625 Lucabaugh Mill Rd. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or iter Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes Give 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Bookbinder Government of Health and Mental Hyg item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James H. Geise Joyce Wyatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 Department of Health ar Important: If item 27 is any injury or other trau Nancy Geise-wife 625 Lucabaugh Mill Rd., Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Page 1 a 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State South Carroll Crem 6/2/12 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility Fletcher Funeral Home f Funeral Service Licensee Signature 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Poset and Death Immediate Cause (Final Pancreatic Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 N Hospital or Attending Physician: 24 hours after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director; After this completely filled in by the funeral di 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a To the Funeral C Medical 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signa DIRECTUR, 31, 2012 Josh Wantiam MEDICAL ONCOLOGY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltrume MD F8515 Johns Hoplans ROSS C. DONEHOWER, MV)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Κ. Greives Mary MAY 30 2012 0250 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital N/A Baltimore City If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours 219-28-2214 Director 1 🗆 M 2 💢 F 79 Dec. 26,1932 Maryland 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Dunda1k 1 Yes 2 No **Baltimore** MD 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 21222 841 Mildred Ave. United States "natural", or items edical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after ☐ Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: White 3€XWidowed 4 □ Divorced Year or Dates. ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Sales Manager 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other th Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Frederick Hartman Stella Hennman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5830 North Hazelwood Ave. Baltimore, Maryland 2120 Barbara Lee Beecy (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . Page 1 cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal Sacred Ht. of Jesus Cem.6/4/2012 Dundalk, Maryland 4 Dopation 5 Other (Specific Fishet 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dudalk, Maryland 21222 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complication shock, or heart failure. List only one cay s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ neu monia disease or condition Medical resulting in death) **Examiner** carcin ma of the comous 5 squertially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as JE FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death 2 No the detached 9 Unknown Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law certificate has autopsy performe 1 ☐ Yes 2 ☐ No 2 N Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this ( in 24 hours after death.

He Funeral Director; After this pletely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury 5 Pending 1 ☐ Yes 2 ☐ No M ☐ Accident ☐ Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) iargni AT2438946 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 30,2012 Year Velva Poore Grebe 12:10AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** c. County of Death
BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 219-01-6449 Director 1 □ M 2 🕅 F November 6,1919 92 Maryland Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 615 Chestnut Ave., #1114 21204 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ARED VEIVA Baltimore, Maryland 21215-0036 Yes 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) secretary medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Viola Taylor Roland Enoch Poore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 E. Padonia Rd. Timonium, MD Roger C. Poore/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Green Mount Crematory May 31,2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses Mitchell-Wiedefeld Funeral Home 6500 York Rd. Baltimore, 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slight, or heart failure. List only one cause on each line.

Immediate Cause (Final CARDIO-RESPIRATORY ARREST Approximate Interval Retween Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** VENTRICULAR ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami ACUTE MYOCARDIAL INFARCTION Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has certificate 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify Funeral Director: After this stely filled in by the funeral di 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work?
1 Yes 2 No 1 Natural 5 Pending Certifical Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 29a. Certifier 🔾 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D31826 5-31-12 mhicum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV RICHARD LINTHICUM, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Mon Registrar

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	Medic Examin		4a. Facility Name (ii	f not institution, give	street and number)			4b. City, Town, o	r Location of Dea			County of Deat		
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2			Linda Qui	lame/Relationship (T net (Daught			2802	Page Drive	and Number or Rural Route Number, City or Town, State, Zip Code)  Pundalk, MD 21222					
Baltimore,					Removal from State	,   06	emetery, cren Hill M	sition (Name of natory or other plac <b>lemorial Pa</b>	rk 05/	Date 26/2012	Lync	cation - City or hburg,V	1	
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23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition condition condition as the condition and the condition and the condition condition and the cond						е.		er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
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°₽,	ted Insit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease of	mmediate erlying	Due to (or as	a consequ	ence of):							
88 10)	te be executed nysician and ne burial-transit	न	that initiated even resulting in death)		Due to (or as	a consequ	ence of):							
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 25 hours after death. The funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the buse.	Physician/Medio	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 - Feta	Ideath 3	Ectopic pregnand Other (specify)	су		2	23d. Date of delivery  Month Day Yes		
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f Vit	Physici this cer al direc	မ	examiner? 1  Yes 2 27. Manner of Deat	MINO	Hospital: 1  Inpat 28a. Date of inj		ER/Outpatier 28b. Time of		4 L Nursing	1			ity) Hospice	
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Divisi	tal or Atters after de al Directo		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		ury - At ho c. (Specify)	me, farm, stre	eet, factory, office			(Street and wn, State)	l Number or Ru	ral Route Number,	
	the Hospi nin 24 hou the Funer Tpleted fill	Medical	(Check only one)	2  Medical Exam 3  Certifying Nur	vsician: To the best on hiner: On the basis of the se Practioner: To the	examination	and/or invest	tigation, in my opini	on, death occurred	d at the time, date	and place,	and due to the	cause(s) and manner stated.	
	North		29b. Signature and	Ptitle of centifier	Chas M.	D		29c. Licens			19d. Date	e signed (Month	n, Day, Year) 2012	
	\		30. Name and add	ress of person who	completed cause of	death (Item	23a) (Type, F	Print) STE 4	105 B	ALTIMOR	E	MD 212	204	
i	Sta	te	31. Date filed (Mon	th. 2012 ar)	32. Reo ti	ar's S	West							

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			State Registrar						ate of L			Reg. N	- / 11	12	1/113
	Physicia	in/	Decedent's Name		_						2. Date of D Month	Da	ay	Year	3. Time of Death
T	Medio Examir		4a. Facility Name (if	Bosili on not institution				4h C	ity Town o	r Location of De	05	23	3 2 c. County	of Doath	0320 A M
-	Examil	lei	University		1		enter	140.0		more	sau i		/a	or Death	
	Funeral Director		5. Social Security N  216-66-52  Usual Residence of	umber 214	6. Sex 1 ∰ M 2 ☐ F		rs. last birthday Yrs.	) If Un Month	der 1 Year	If Under 24 F	Hrs. 8. Date of B (Month, E March	irth Day, Year)		Count	lace (State or Foreign ry)
	and show at	ě	10a. State	10b. County		10c.	City, Town or I	Location	1					1	0d. Inside City Limits
	Maryla 28a-f etified	Director	MD	Balt	imore		Cockeys	vill	e						1 🗆 Yes 🗶 No
	h the sa or s	al D	10e. Street and Nun					10f.	Zip Code			10g. C	itizen of W		-
	ith with miss 2% must	Funeral	210 Warre	en Rd.	10 1// D	- I - I Fire in	110	) W D-		030	/O!f - V N1			USA	
21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		If the Gi					ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	)~		e - America k, White, e <b>W</b>	
2-0	2 hour "natu	plet	(Spe	15. Decede	nt's Education est grade completed		16a. Dec		sual Occup	ation during most of v	vorkina	16b. l	Kind of Bu	siness/inc	lustry
121	thin 73 ene. than the Me	Completed	Elementary/Seco		College (*		life.	DO NOT	use retired) Carri		roming	IIC	Dogt	1 Co	rvice
d 2	filed within al Hygiene. <b>I other tha</b> vent, the N	0	17. Father's Name (	First, Middle, I			Let	ter	Carri		Name (First, Middle				rvice
/an	l be fil fental rrked tic ev	ပ	Anthony 1								J. Fish	o, maraon		,	
Maryland	1 and 2 should be file of Health and Mental I item 27 is marked o other traumatic eve		19a. Informant's Na	ame/Relations	hip (Type, Print)		19b. Ma	iling Addr	ess (Street	and Number or	Rural Route Numb	oer, City o	r Town, St	tate, Zip C	ode)
	and 2 s Health tem 27		Mrs. Mar		sso/wife					d., Coc	keysvill	e, M	D 210	030	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		4 Donation	☐ Cremation 5 ☐ Other (S		State		vall	ey Me	moria1	/1 <sup>Date</sup> 12 Gardens	Tim	oniur	n, MD	
Bal	permit Depar Impor any in		21. Signature of Fur	11/11/2				22. Name Lem	and Addre	ss of Facility uneral	Home of TImoni	Dula	ney_V	/alle	y, Inc.
			23a, Part 1, Enter t	he disease, or	Flagle complications that	caused the d							MD 2.	1093	Approximate
Å,	Physician/		Immediate Cause (	Final	only one cause on ea	ach line.	0	١	an anno	da					Interval Between Onset and Death
	Medical		disease or conditio resulting in death)	n	a. Due to	(or as a cons		liom	Aples	Try				-	
	Examiner	٦	Sequentially list co	nditions,	b. ———									_	
. 1	ed isit	Examine	if any, leading to in cause. Enter Under Cause (Disease or	imediate dving	Due to	(or as a cons	equence oi).								
京	executed ian and urial-transit	Exa	that initiated events resulting in death) I	s ´	c. Due to	(or as a cons	sequence of):								
V	e be e iysiciar ne buri	lical			d										
876	tificat ing ph e as th	Мес	IF FEMALE:		CONTROL -							1			
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	23b. Was decedent in the past 12 r 1 Yes 2 Unknown	months?		Birth 2 🗌 1 Inant at time	etal death 3	☐ Ectop ☐ Other		ру 			23d. Date Mor	e of delive	ry Day Year
P.O.	that the led by detact	by Ph	Part II. Other signif	icant condition	ons contributing to d	leath but not	resulting in the	underlyir	ıg cause giv	ven in Part I.	23e. Did	tobacco	use contri	bute to the	e cause of death?
1s,	uires in sign	ed b	Hyperten	sion							_ 1 🗆	Yes 2	□ No	3 🗌 Prob	ably 4 Unknown
Sor	aw red as bee 2 sho	Completed	Coronary	Arter	y Disease						24a. Wa	s an opsy			sy findings available
Rec	The la ate ha	Com	1-2.00.000000000000000000000000000000000								_ per	formed?	d	eath?	_
tal	sician: The certificate irector, pag	Be	25. Was case referre examiner?	_/	Hospital:				To	ace of Death (C	heck only one)				
έVi	Physi this o	2	1 Yes 2	No	1 28a. Date		ER/Outpati			4 U Nursin	g Home 5 Res				
n 0	ding th. After fune	cate	1 Natural 2 Accident	5 Pendir	g (Mon	th, Day, Year	injury		28c. Injury		28d. Describe	how inju	ry occurre	a	
Division of Vital Records,	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certificate:	3 Suicide 4 Homicide	6 Could	not be 28e. Place	of Injury - Aing, etc. (Spe	t home, farm, s cify)			100 2 2 110		(Street ar own, State		r or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 (Check 2	Certifying  Medical E	Physician: To the baxaminer: On the bax	est of my kn	owledge, death	h occurred	at the time	e, date and place	e, and due to the	cause(s) a	and manne	er as state	d. se(s) and manner stated.
	the lithin 2 the l			Certifying	Nurse Practitioner			e, death o		he time, date an		the cause	e(s) and ma	anner as si	tated.
24	F ≥ F 8		Consu		id						24.1		ate signed $3/12$		ray, Italij
U	140		30. Name and addre			se of death (I	tem 23a) (Tvpe		14 14c	89963	510	-12	7, -		
	M,		Consuelo De	and i					MD	21201	_				
	Star Registra		31. Date filed (Month	n, Day, Year) 1 2012	32. F	Registrar's Sig	grature and	p.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma		partment <i>ertificate</i>				iene 2	2012	17	116
	Physic		1. Decedent's Neme (First, Middle, Last Rosa Lee Goins	)					2. Date of Deat Month May 25,	Day	Year	3. Time of 1	Death A <sup>M</sup>
-44	/Medi Examir		4a. Facifity Name (If not institution, give 2602 Lauretta Aver		***		own, or Locatio		nay 25,		unty of Deeth	10.50	A
	Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthd	ay) If Under 1		ler 24 Hrs. s Min.	8. Date of Birth (Month, Day, 9/6/2	Year)	Cour	face (State or try) n Caro	
	show	ō	Usual Residence of Decedent  10a. State 10b. County		r Location			1	0d. Inside City				
	vith the h	Director	MD  10e. Street and Number		Ва	altimore 10f. Zip (			10	0g. Citizer	of What Cour		
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show maric svent, the Wadreal Exeminer man be mortified at	by Funerai	2602 Lauretta Ave  11. Marital Status  1 Never Married 2 Married  3 M Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ★ N If Yes, Give		3. Was Decede If Yes, specif		Origin? (Spe can, Puerto I	cify Yes or No- Rican, etc.)		USA Race - Americ Black, White,	etc.	
21215-0036	within 72 hou ane. Ihan "natural	Completed t	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	Year or Dates: cation e completed) Coflege (1-4or 5-	(G lift	ocedent's Usual ive kind of work e. DO NOT use	done during m retired)		ng	Black 16b. Kind of Business/Industry Home			
Maryland 2	를 를 를 돌	To Be Co	17. Father's Name (First, Middle, Last) unknown		D(	omestic	18. Mot		(First, Middle, A				
	s 1 and 2 should If Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Elizabeth S. Jones			aifing Address (	Street and Num	ber or Rura	Route Number,				
altimore,	0 0		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	1	sposition (Name crematory or oth Park Ce	er place)	D	ate 2	20c. Locat	ion - City or To more, N	wn, State	ıd
Balt	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service Licens	Cart	> 1	22. Name and	Address of Fac	ility Lou	don Parl altimore	c Fun	eral Ho	ome	
	Physician /Medical Examiner	ner	23a. Pert1. Enter the disease, or coordinates, or the art failure. List option of mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to him addate cause. Enter Undertrying	Due to (or as a	the death. Do not a consequence of):		of dying, such a		r respiratory arre	est,		Approximate Interval Betw Onset and Do	een
8/60,	cate be executed physician and the burial-transit	dicai Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):								
BOX 6	death certifi a attending I d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	3c. If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetel death	3 ⊡Ectopic preg 5 □ Other <i>(spec</i>				23d.	Date of delive	*	ar .
ras, P	requires that the een signed by the hould be detache	þ	Part II. Other significant conditions cor	tnbuting to death but	not resulting in the	underlying cau	ise given in Par	t I.			contribute to th		
Hec	The lay ate has page 2	e Completed	25. Was case referred to medical							ed?	4b. Were autop prior to con death? 1  Yes	pletion of cau	vailable use of
5	ling Phy	Certification: To Bo	examiner?  1  Yes 2 No  27. Manner of Death  1  Abaturaf 5  Pending  2  Accident investigation	ospital: 1 🗀 Inpatien 28a. Date of Injury (Month, Day	28b. Time	of 28d		Nursing Hom 2	(Check only one le 5 XI esider 8d. Describe hor	nce 6 🗆		)	
			3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injur building, etc.	(Specify)			į	Bf. Location (Str. City or Town,	State)			9 <i>r</i> ,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	one)		examination and/or	investigation, in	i my opinion, de	eath occurre	d at the time, da	te and pla	ce, and due to	the cause(s)	
	/ 1		29b. Signature and title of certifier  30. Name and address of person who co	he Con	ned M	5	738	76:	2	0	5-29	-/2	
	r) V		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Typ	e, Print) S vite 18	haron	alti.	nove, 1	mack 1d. o	MO		
	Sta Registra	e ar	MAY 3 1 2012 /	Reput Hegistra	o Signatura	(2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY Physician/ <sup>Day</sup> 2012 8:08a M 28 JAY MICHAEL GOODMAN SR. Medical 4a. Facility Name (if not institution, give street and number) Examin<u>er</u> 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CENTER TOWSON 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Min 212-44-1438 1**X** M 2 □ F Director 64 6-28-1947 MARYLAND show 10b. County 10d. Inside City Limits 10c. City, Town or Location event, the Medical Examiner must be notified at Director 28a-f 1 X Yes 2 No N/A BALTIMORE MD. 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 USA 4230 HOLLINS FERRY RD. APT 101 items be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc. ō 1 Never Married 2 Married 1 XYes Completed by 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: BLACK 3 Widowed 4 Divorced Specify. "natural", Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) STATE OF MARYLAND ELECTRICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is marany injury or other? is marked ျ ARNETTA PAULS JAZEE GOODMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4712 HAMPNET AVE. BALTIMORE, MARYLAND 21214 RONDA GOODMAN (DAUGHTER) 20a. Method of Disposition
1 ☑ Burial /2 ☐ Cremati 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) on 3 Removal from State GARRISON FOREST VETERANS 6-6-2012 OWINGS MILLS, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service LicensecTONATHAN D. HIBN 122. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Cause (Final Immediate Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 2 2 No 1 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 Tes 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Acther (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Natural (Month, Day, Year) injury 5 Pending 2 No 1 Yes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Descritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number MD 71046

Registrar

DHMH 17 Rev 06-2011

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOMAR

6701

within 24 hours af er death.

To the Funeral Director

Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registrar

30. Name and address of person who completed cause of death (Item 23a)

ignature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per fh g928 6-16-12 vt. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:50 AM 2012 iam May Medical 4a. Facility Name (if not institution, give street and number) 4b. or Location of Death 4c. County of Death Town **Examiner** Baltimore as pita -bor If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 09/12/1953 217-64-1301 58 Director 1 X M 2 X 1 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Maryland Baltimore Monkton 1 Yes 2 X No 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21111 17321 USA Big Falls Road death v 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. by 1 Never Married 2 Married within 72 hours after altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal. 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Northrop Grumman College (1-4 or 5+) Elementary/Secondary (0-12) 2 Electronic Engineer years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William P. Harvey Sr. Corrine Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaSendle Burgess/daughter 17321 Big Falls Rd. Monkton, MD. 21111 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 06/027/12 cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Dulaney Valley Mem. Gardens 22. Name and Address of FacilityChatman-Harris Funeral 21. Signature of Funeral Service Licenses Home 5240 Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final > Phytician Atherosclerotic a trobable disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examin burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day 5 Other (specify) Year be detached the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed should peen s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has autopsy performed page 2 certificate Yes 2 🗹 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury ■ Natural 5 Pending work?
1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 25, cause of death (Item 23a) (Type, Print) 3001 South Hanover Street, Baltimore, MD State Registrar

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 4:45 Physician/ Mayoth 23 Eleanor Wafer Huntley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oak Crest Nursing Center Parkville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Sept 24, 1921 Mary and Director 214-14-9623 90 3 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at with the Maryland Director 1 Yes 2 No Parkville Baltimore Maryland Huntley, Eleanor 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8800 Walther Blvd. 21234 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Deceue... Armed Forces? 1 Yes 2 No the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Narried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " Johns Hopkins life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) University Hospital 12 Administration other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Mildred Marquerite Reinhardt Bernard Edward Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trateonce. P.O. Box 2963 Ellicott City, Maryland 21041 John D. Wafer altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State May 26, 2012 Hilltop Service Corp Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service Licensee Michael Neiser Dada-Ruck-Furrer Etill Home Of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hypertensive Cardiovascular Disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform this certificate Yes 2 No or Attending Physician:
after death.
Director: After this certific 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 1 Tyes 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Mursing Home 5 Residence 6 Other (Specify) funeral ( 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 5 Pending 1 Tes 2 No Investigation completed filled in by the Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) chealle R171944 5-25-2012 who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blod, Parkville MD 21234 G Harrison NP State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

5/25/12

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 per FH G9286/06/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 | 2

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY Month WILLIAM 26 2012 J. HAIRSTON 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPTIA TAKOMA PARK MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, AUG. 3 1943 1948 9. Birthplace (State or Foreign **Funeral** 227-56-5114 WEST VIRGINIA 68 **Director** 1 🗓 M 2 🗆 F Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No DC WASHINGTON 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 301 DELAFIELD PLACE N.W. 20011 USA items 2 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. BLACK "natural", 3 Widowed 4 X Divorced Specify. Completed , be filed wu.. Mental Hygiene. ∵•d other than "nau.. •t, the Medical Ey 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other transmission. 10TH BARBER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JAMES HAIRSTON ELISSIE WALLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHANIE MARSHALL/DGT. 7100 HANOVER PKWY # C-2 GREENBELT, MARYLAND 20770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/6/2012 RIVERDALE CREMATORY RIVERDALE MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Eyiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical (or as a consequence of) **Examiner** noumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-tra resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Overgnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Por in the past 12 months? Dav signed by the at 2 No 9 Unknown Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown Completed ortonsio 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 No 1 Yes 2 No Yes Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 / No 욘 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗀 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/27/12 on who completed cause of death (Item 23a) (Type, Print) Rd # ZIB ROCKVILLO MB 20852 Randelph State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Dorothy Catherine Hennegan May 1:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Baltimore Parkville Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Hours Months Min. (Month, Day, Year) **Director** 215-18-9079 1 □ M 2 🗓 F Yrs. 89 Feb. 5, 1923 Usual Residence of Decedent Maryland show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 🗆 Yes 2 🔀 No Maryland Baltimore Parkville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8800 Walther Blvd. U.S.A. ral", or items ? I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No or i Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural" 3 X Widowed 4 Divorced Specify: White Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Administration Secretary University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Conrad Kaifer Catherine Fuchs and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Mary H. Jenkins (daughter <u>33340 Galena Sassafras Road</u> Galena, Maryland 21635 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Grdns. 5-31-12 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Titchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Mary 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Immediate Cause (Final Onset and Death Cardiovascular Disease Physician/ pertensive disease or condition resulting in death) Medical Due / (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for at a contraguence of: burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the JE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzhumurs 2 XNo 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA upletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ar 29d. Date signed (Month, Day, Year)

Registrar

State

8800 Walther Blad, Parkville MO 21234

CANP. COST

20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12:26 AM Physician/ OLMA Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Examiner** baltimore ORleans If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday, If Unde 8. Date of Birth (Month, Day, Year) **Funeral** Months 9152 1 □ M 2 🗂 Director 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho, amy injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Md. BOLL MORE 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number USA Funeral ORLeans Steel 21231 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Be 17. Father's Name (First, Midelle, Last) 2 19a. Informant's Name/Relationship (Type, ute Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other p Burial □ Cremation 3 □ Removal from State vestem 5 Other (Specify) 4 Done ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re Approximate Interval Between 23a. Part 1. Enter the di shock, of heart fail re. List only one cause on each line. Onset and D Immediate Cause (Final disease or condition HS Provide and MONTO Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last aftending physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the dea h certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death been signed by the artendi-should be detached for use 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 mosths?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1  $\square$  Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an reral urector. After this certificate has relified in by the funeral director, page 2.3 autopsy 1 🗌 Yes 2 🗍 No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Residence 6 - Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Manner of Death 28b. Time of 28d Describe how injury occurred 1 Natural 2 Accider iniury 5 Pending 2 🗌 No within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely only one 29b. Signature and title of certific 25 0(2 30. Name and address of person w

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/ Medical Examiner  1. Decedent's Name (First, Middle, Last)  Merlin M. Hamrick  Medical 4a. Facility Name (if not institution, give street and number)  Figure 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday)  The security Number 1 Sex	n	eath (	Day Year 3. Time of Death 29 2012 1125 AM  4c. County of Death Beltimore									
Physician/ Medical Examiner  4a. Facility Name (if not institution, give street and number)  FIRMILLIA SQUARE HOSPITCE  5. Social Security Number  6. Sex 7. Age (in yrs. last birthday)  Mod	Roseda   If Under 24   Inthis Days Hours N	2. Date of Death Month  eath   Irs. 8. Date of Birth	Day Year 3. Time of Death 29 2012 1125 AM  4c. County of Death Beltimore									
Funeral  4a. Facility Name (if not institution, give street and number)  4b.  FRANKLIN SQUAFE HOSPITCE    5. Social Security Number   6. Sex   7. Age (in yrs. last birthday)   If Umber    33.3   3.5   5.35.0	Roseda   If Under 24   Inthis Days Hours N	eath  Hrs. 8 Date of Birth	4c. County of Death  Boltimore  9 Birthplace State or Foreign									
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If V	Under 1 Year   If Under 24   nths Days Hours N		9 Birtholace (State or Foreign									
232 26 5250 Mor	nths Days Hours N		9 Birtholace (State or Foreign									
		July20,	ar) Country)									
Ligural Possidence of Decedent			1927 WVA									
पुर्व है । 10a. State   10b. County   10c. City, Town or Location	River		10d. Inside City Limits									
MD Baltimore 10c. City, Town or Location Middle			1 ☐ Yes 2 🛣 No									
Toe. Street and Number	Of. Zip Code	10g	. Citizen of What Country?									
3307 Gentian Lane  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was D	21220	)	USA									
1 Never Married 2 Married 1 Yes 2 XIo	Decedent of Hispanic Origin? , specify Cuban, Mexican, Pu Yes 2 XNo S <i>pecify:</i>	(Specify Yes or No- lerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White									
15. Decedent's Education (Specify only highest grade completed) (Give kind of Give	Usual Occupation	161	b. Kind of Business/Industry									
3 Widowed 4 Divorced If Yes, Give Year or Dates.  15. Decedent's Education (Give kind of life. Do No Home)    Specify only highest grade completed (Give kind of life. Do No Home)	of work done during most of the control of the cont	,	1.									
S T T T T T T T T T T T T T T T T T T T	maker		own home									
Strain and the strain	- 1	Name <i>(Fir</i> st, <i>Middle, Maic</i> Itie Morri	•									
J B D N W L ST WAR AND A ST WAR												
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Add  3307  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  19a. Informant's Name/Relationship (Type, Print)  20b. Place of Disposition  1 Burial 2 Cremation 3 Removal from State  19a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	dress (Street and Number or Gentian La		ore MD 21220									
20a. Method of Disposition  20b. Place of Disposition  1 Burial 2X Cremation 3 Removal from State  20c. Place of Disposition	(Name of y or other place)		c. Location - City or Town, State									
1 Burial 2X Cremation 3 Removal from State Bayview C.	rematory 5	/30/12	Baltimore MD									
22. Nam	ne and Address of Facility  onnelly Fun		Ave. Balto. MD of Essex 21221									
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.			Approximate Interval Between									
	Immediate Cause (Final disease or condition resulting in death)  a. Acut a ridal infauction  Due to (or as a consequency of):											
Examiner Due to (or as a consequence or):	a die											
Sequentially list conditions, b. Colonar array array leading to immediate be be to for as a consequence of):	Sequentially list conditions, if any, loading to in modiate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Colonary artery disease.  Let use a consequence of):  Hypertension											
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e la												
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Hypertension  Due to (or as a consequence of):  If FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy	ia											
IF FEMALE:												
in the past 12 months?    Compared to the past 12 months   1   Live Birth 2   Fetal death 3   Ector	opic pregnancy er (specify)		23d. Date of delivery  Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?									
Sensigna de mintia		_ 1 ☐ Yes	2 No 3 Probably 4 Unknown									
cor as be 2.2 sh		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of									
The harden		performed	? death?									
25. Was case referred to medical examiner?	26. Place of Death (C											
Hospital: 1   Inpatient 2   ER/Outpatient 3		Home 5 Residence	6 Other (Specify)									
28a. Date of injury 28b. Time of injury 28b. Time of injury	28c. Injury at work?	28d. Describe how in	jury occurred									
To		20f Location Street	and Number or Rural Route Number,									
Division of Mital Becords, and the final state of t	ictory, office	City or Town, Sta										
Division of Vital Records, within 24 hours after death.  Part II. Other significant conditions contributing to death but not resulting in the underly property of the form of the following state death.  Part II. Other significant conditions contributing to death but not resulting in the underly property of the following state death.  Part II. Other significant conditions contributing to death but not resulting in the underly property of the following state	n, in my opinion, death occurre	ed at the time, date and pla	ace, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier	29c, License number		Date signed (Month, Day, Year)									
freel.	000533	13 5	129/2012									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR Thomas Krisanda 9000 FAAN			to md 21237									
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature 33. Across 6. Across 6.												

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gary Russell Horva	1	- For State	tate	of Maryla		epartme Certifica			d M	ental Hy		2 l	017	2	712
Physician Medical Examine	1	Registrar  1. Decedent's Name (First, Mid GARY I		sell	НО	RVATH	[				2. Date of Deat Month May 27, 20	h Day Yea		3. Time of 0942	
	•	4a. Facility Name (if not institu 28 Oak Road #C	ion, give	e street and nui	mber)		4t	. City, Town, or Middle Rive		ion of Death		4c. County of Baltimor		nty	
Funeral Director		5. Social Security Number 220 – 78 – 1941	6. Se	2 F	7. Age (In )	yrs. last birth	Yrs.	Months Day	_	Jnder 24Hrs. ours Min.	-	h(мм/DD/YYYY -1960	Foreign	1	ate or MD
nd skow any sce.	ľ	Usual Residence of Decedent 10a. State 10b. Count MD CAI	y RROI	LL	10c.	10c. City, Town or Location SYKESVILLE									e City Limits
n the Maryland 3a or 28a-f show; offfice at once.	_ I	10e. Street and Number 6790 WHITE I	ROCI	K ROAD		10f. Zip Code 21784			1	10g. Citizen of What Co					
215-0036  be filed within 72 hours after death with the Maryland mal Hygiens free inher than "natural", ur items 23a or 28a-f she ent, the Medical Examiner must be notified at once Ba Compileted by Finneral Director			ivorced	1 Yes If Yes, Give Year	rces? 2 💢	No	If Yes	s, specify Cubar es 2 No	n, Mexi	ican, Puerto		White Specify:	wH]		8lack,
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiera.  Important: If tiem 27 is marked after than "natural", injury ar other traumatic event, the Medical Examiner.  To Be Commisted by 1	- Inpleton	15. Decedent's Education (Sp Elementary/Secondary (0-12 8	2)	College (1-		d) 16a. D	uring mos	Usual Occupa t of working life	e. DO N	IOT use retir	ed)	16b. Kind of 8u	TRUC		N
21215-( ould be filed d Mental Hyg s marked nth tite event, the To Be Co	3	17. Father's Name (First, Midd GEORGE	J.	HOR		, JR.		Address (Stree	J	JOAN		Maiden Surname) MO ber, City or Town	RGAN		
re, MD 1 and 2 sho 2 Health and fitem 27 is er traumati	L	GEORGE J. HO  20a. Method of Disposition  1 Burial 2 Cremati	ORV <i>I</i>	ATH, J	R.	0b. Place of		WHITE			OAD S	YKESVI			
Baltimore, pemit. Pages la Department of He Important: Uite injury nr other the	1	4 Donation 5 Other 2. Signature of Funeral Service	Specify:				22. Na	EMATOR	s of Fa	cilityCVA	CH/ROS	CATON: EDALE I SEDALE	FUNE	ERAL	
Physician /Medical Examiner		23a. Part I. Enter the disease, failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	se on ea se a. <b>F</b>		and 1	nethad					respiratory arre	est, shock, or hea	irt	Between	nate Interval I Onset and Death
nsi e de Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death). Las		sequence of): sequence of):											
be executed in the second and unial - tra	<u> </u>	X UNPENDED					7,28	a-f,per	me	<b>,</b> g928	6-4-12			-	
Division of Vital Records, P.O. Box 68760, To the Hospital w Attending Physician: The law requires that the death certificate by within 24 hours after death.  The the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the buredical Certification: To Be Completed by Physician/Meredical Certification:	2:	F FEMALE: 3b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 U			rth int at time o	2	=	death 3 r (Specify)	Ect	opic pregnar	ncy	23d. Date of Month	delivery Da	ay	Year
ls, P.O. Equires that the densigned by the detached		Part II. Other significant cond Cocaine Use	itions	contributing to	death but r	not resulting	in the un	derlying cause o	given ir	Part I.	_	2 No 3	Proba	bly 4 🗸	
Division of Vital Records, state dear equires and artending Physician: The law requires and refer death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed	) L										autops perform 1 Yes 2	sy pi med? de		mpletion o	f cause of
Vital hysician hysician this certi	í	25. Was case referred to media examiner? 1 ✓ Yes 2 No		lospital: 1 In	patient 2	ER/Out	tpatient		Other <sub>4</sub>	ath (Check o		Residence 6	Other:	Scene	
on of \ cending Physicath. or: After the funeral utilion: Telling Itellians.		27. Manner of Death 1 Natural 5 Pe	nding	28a. Date of (Month,	of Injury Day,Year)	ľ	ime of Inju	4□.			28d. Describe h	ow injury occurre	ed .		
Division o  To the Hospital ur Attending within 24 hours after death Th the Funeral Director: Art completely filled in by the fune edical Certification:		3 Suicide 6 X Co	estigation uld not be termined	28e. Place	of Injury -		m, street,	factory, office b	ouilding		28f. Location (S or Town, St Middle	treet and Number ate) 28 Oak River, MD	r or Rura <b>Gro</b> v	Route No	umber City
To the Hos within 24 h Thathe Fun completely		one) 2 Medical Ex	aminer		examinati	-		n, in my opinior	i, death	occurred at		e(s) and manner and place, and du	ue to the	cause(s)	
		29b. Signature and title of certi	~	- Pol	lu of death (	Itom 23c)	*	29c. Licens				29d. Date signe May 28, 20	•	п, µау, Үөг	ar)
$\mathbb{Q}$		Patricia Aronica-Poll		). Assista	nt Medic	al Exami		00 W. Baltir	nore	Street, Ba	altimore, MD	21223			
State Registra		1. Date filed (Month, Day Yea	1	32. Reg	istrar Sig	mature Contraction	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :55A Walter 28 2012 Medical Harris 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 62 **Director** 215-52-3194 1X M 2 🗆 F Oct.4,1949 MD Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director must be notified Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral USA 5946 St.Regis Rd 21206 and Mental Hygiene. is marked other than "natural", or items? aumatic event, the Medical Examiner mu. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Loudon County Elementary/Secondary (0-12) College (1-4 or 5+) High School 10th Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mattie Solomon Re 9 Walter L. Harris, 2012 19a. Informant's Name/Relationship (Type, Print) Victoria Jackson Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5946 St. Regis Rd. Balto, Md. 21206 Department of Health Important: If item 27 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) June 4,2012 Balto, MD King Mem.PK. 4 Donation 5 Other (Specify) lure of Funer Uservice Light see 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 21213 Ε. Preston St. Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RENAL DISEASE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease Or it that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 WALTER HARRIS 38 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d, Date of delivery page 2 should be detached for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform certificate Yes 2 X No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at eral Di ector: After filled ir by the funer 28d. Describe how injury occurred X Natural work? 1 Yes 2 No 5 Pending injury after death. ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check only one) within 2 29b. Signature and title of certific 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 06-201

State

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TRACIE L. MORGAN, CRNP

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Ireland Francis Scott 29 2012 May 13:25 PM Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harbor Hospital Center Baltimore Baltimore City Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours 219-07-9229 **Director** 1 XM 2 □ F 92 June 12, 1919 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location Director MD 1 Yes 2 No Anne Arundel Co Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 419 Cleveland Road 21090 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black. White, etc. þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🕅 Widowed 4 □ Divorced If Yes. Give White WWII Completed Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 9 vrs. College (1-4 or 5+) Truck Driver yrs. Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin Samue1 Ireland Nettie Catterton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Mr. Gary Ireland 610 Cleveland Road Linthicum, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 06/04/2012 Glen Burnie, Maryland 21, Signature of Funeral Service Licer 22. Name and Address of Facility Singleton Funeral & Cremation M01121 2nd Ave SW; Glen Burnie, MD 21061 Service PA; 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Induct Immediate Cause (Final Physician/ Nyocar disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Examir attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 L 9 Unknown Yes 2 No signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate 1 🗌 Yes 2 🗆 No Yes 2 N Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifics funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ည 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? **V** Natural injury 5 Pending М Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 h To the Fur Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

viation Bld Glen BurnisMD 21061

no completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY 26, 2012 EMMA L. JOHNSON 6:00 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1637 PLEASANTVILLE DR. GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Min. Country) 1 M 2 XX **Director** 218.26.9239 80 MAY 16, 1932 28a-f show 10a. State 10b. County than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD ANNE ARUNDEL 1 ☐ Yes XX No GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1637 PLEASANTVILLE DR. 21061 USA within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes, Give XX No Maryland 21215-0036 1 ☐ Yes 💥 No Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates. WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 PAUL DIVEN MAY NETTE BURROWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 stoff Health a permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr DEBORAH A. BRATCHER 7109 ST. LAUREN CT. BALTIMORE, MD 21226 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE CEMETERY 5.31.2012 ELKRIDGE, MD 21. Sign him of Funeral Service Laceme FINK FUNERAL HOME, P.A. 426 CRAIN HWY SW CLEN BURNIE, MD 21061 FINK M01148 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a con uence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events and -trar Due to (or as a consequence of) resulting in death) Last ng physician as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 2 No 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🗷 Natural 5 Pending Accident Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 24 ho To the Fune completely f (Check the Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, 32. Registrar State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ma 2:25QM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death teathcare TIGHS Kesvil 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 1 № M 2 🗆 F Days 215-46-Months Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important I fleem 27 is anarked other than "natural", or items 23a or 28a-f sho may injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director arroll MD 1 Xes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Ness 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Blac 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Army Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cara altimore, Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Mills, 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Cardiwaschlar Physician Atheroscelortic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No page 2 should be detached for Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 N 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Acciden Accident Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only on 29b. Signature and title of 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) westmister MAHMOUD 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 26,30 per verb . 127,05/31/2012dhb Reg. No. State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Charles Townsend Jones  $AM^M$ 01 Medical May 4 10:34 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15007 Birmingham Drive Burtonsville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director 096-09-7097 1 X M 2 🗆 F 91 July 24, 1920 New York Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD 1 Yes 2 X No Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 625 Whitingham Drive 20904 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Yes f Yes, Give 2 No filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify white Specify: "natural" Completed 3 X Widowed 4 ☐ Divorced 43-46 Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>operating engineer</u> excavation permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumair: once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Chester Prince Jones Edna May Townsend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Jones/son 15007 Birmingham Drive Burtonsville, MD 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) d S. Wede Signatur, or Funeral Service 22 Name and Address of Facility Board 655 W. Baltimore Street Director 222 Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physics m/ myleodysplastic syndrome disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death 4 ☐ Pregnant a 1 ☐ Yes 2 ☐ 9 ☐ Unknown be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? After this certificate has 1 Yes Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Son's

Other (Specify) Resisdence Other: 4 Nursing Home Hospital: 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred or Attending Natural injury 5 Pending death. 2 Accident
3 Suicide Investigation within 24 hours a er deal To the Funeral Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year, May 8, 2012 D 37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Coleman MD, 1355 Piccard Drive, Suite 100, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parker

DHMH 17 Rev 06-2011

Registrar

MAY 3 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician/ 06:08 AM MTCHAEL. E. JACKSON 201 May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Sinai Mos bital Baltimore Balnmo Michael Jacksor 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 578-74-9645 1 X M 2 □ F Director Yrs. DEC. 10 1954 MARYLAND 57 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State **Funeral Director** 1 🗓 Yes 2 □ No PRINCE GEORGE'S NEW CARROLLTON MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 50 must be 23a 6109 WESTBROOK DRIVE 20784 items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 X Yes 2 No MARINES Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. BLACK "natural", 3 Widowed 4 Divorced Completed KNBWNGS er than "natura", the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygienes Important: If item 27 is marked other than any injury or other traumatic event, the Nonce. BUS OPERATOR PRIVATE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ ERNEST JOHNSON BLANCHE JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE D. JACKSON/WIFE 6109 WESTBROOK DRIVE NEW CARROLLTON, MARYLAND 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) MD VETERANS CEMETERY 6/5/2012 CHELTENHAM, MARYLAND . Signafore of Funeral Service Licer 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Naphney 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Myorandia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying and Il-transit law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the aid be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed l Disorder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? idemi 1 Yes 2 No certificate 21 N Yes 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 28b. Time of 28d. Describe how injury occurred Certificate: After t 1 Natural 5 Pending 2 No Accident Investigation 6 Could not be Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 4 Homicide City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 000 & ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 130 PM 201 Max Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** # Silver Pring 616 ontgomer If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) Social Security Number **Funeral** - 46-4600 1 🗆 M 2 🗶 F Months Days Hours Min Director November ZE Washington Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mattinal at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director Maryland 1 Yes 2 No MO Omer 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Š altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, ٥ Krown Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blvd #610 Many knd 20902 indon B 20c. Location City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Pleasant Valley Memorial Park Juney, 2012 Annandale 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Funeral Service obert B Shirlington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER DVARIAN lyea. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fetopic pregnancy in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No After this certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \mathbb{R} \) Residence \( 6 \) Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Certificate: ★ Natural 5 Pending hours after death. uneral Director: Al 2 🗌 No Investigation Accident Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D54378 5/29/2017

Registrar
DHMH 17 Rev 7/2009

State

2730 University Blud W

Suite 400

Wheaton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Worth

MD

32. Registrar's Signature

Axles

31. Date filed (Month, Day, Year)

MAY 3 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Jackson Jr. 2012 Alphonso 26 5:20a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Future Care Nursing Home</u> Baltimore Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days Months 1 🔀 M 2 🗆 F Hours Director 213-30-0003 MD 78 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore NA Y Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 3818 Belle Ave "natural", or item ledical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Black 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Shop Mechanic 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Isabelle Galvin James Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 3818 BelleAve, Baltimore, Md 21215 Shelwyn Gaskins-Niece or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/2/2012 Baltimore, Md On-Site any in 22. Name and Address of Facility
March F/H West 21. Signature of Juneral Service Lig 300 Wabash Ave Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Enysician METASTATIC UNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner KESPIRATURY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year certificate has been signed by the a rector, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 No director, 25. Was case referred to medical 8 B 26. Place of Death (Check only one) examiner? Hospital 2 No |으 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28b. Time of 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No s after de... eral Director: A: filled in by th ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 30 2012 ( Mus 71264

State Registrar UZO UNEGBUMO. 4800 SETON DR BATIMORE, MD
31. Date filed (Month, Day, Year)
32. Frietran's Signature.

MAY 3 1 2012 Command. Aparel

30. Name and address of person who completed caus

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21215

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 24, 20°12 William B. Johnson, Sr. 10:57 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 13 Cinder Road Timonium Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) 218-40-9288 **1**XX M 2 □ F Director 11-20-1943 68 Maryland Usual Residence of Deced 10a. State 10d. Inside City Limits "natural", or Items 23a or 28e-f sho 10c. City, Town or Location Director 1 Tes 2 X No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13 Cinder Road 21093 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No þ Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify White 3 Widowed 4 Divorced Completed The Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72? Department of Health and Mental Hygiene, Important: If Item 27 is marked other then "na any injury or other traumatic event the proce." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Letter Carrier Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bernard H. Johnson Anna Marie Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Cinder Road, Timonium, Maryland 21093 Charlotte Johnson - wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Meadowridge Mem Park :05-29-2012 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock Immediate Cause (Final disease or condition Physician/ LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the buria Physician/Medical Vital Records, P.O. Box 68760 IF FEMALE WILLIAM JOHNSON SR. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery To the Hospital or Attending Proystorian, the form and within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for i 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) 2 🗌 No q Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: မ 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 IDOA ð 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicíde 5 Pending injury Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Days Hours Min Country) Director 212-86-5241 51 PA Usual Residence of Decedent or 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Howard Elkridge 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6250 Sandrise Court, Apt 204 21075 United States items ? 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or ≥ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify 3 Widowed 4 XXDivorced Specify Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien. I is marked other th Office Administrator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Hibbard Eileen Tipping 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is: 5529 Hunting Horn Dr., Ellicott City, MD 21043 Alexandra Marker - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) 05-22-2012 Glen Burnie, Maryland 21. Signat Funeral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP 7250 Wash. Blvd. Inc \_Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line 1 Immediate Cause (Final Onset and Death Phylicin disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death by the Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy certificate 1 Yes PNo 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X**No Certificate: To 1 Tes 1 Xnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marie Margaret Jenkins May 26<sup>Day</sup> 2012 1:32 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 9607 Baron Place Rosedale Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 213-26-3895 Hours **Director** 1 🗆 M 2 💢 F 91 Julv26,1920 Maryland or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Funeral Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 9607 Baron Place U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Food Industry Assembly Line Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Bovkin Mary Grossman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9607 Baron Place, Rosedale, Maryland Richard R. Jenkins: Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National Cemetery 6-1-12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CHRONIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner countings list even littens Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 JOSK W. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform To the Hospital or Attending Physician: The certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပု 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify, To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 🗌 Yes 2 🔲 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fit 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 10N 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Christopher Shawn Kelley рМ May 2012 Medical 26 2:32 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 263-61-3179 Country) 1 🛛 M 2 🗀 F 39 Usual Residence of Decedent Sept.7,1972 Florida 28a-f show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1603 Sherwood Road 20902 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force ð 1 Never Married 2 KM Arried Black, White, etc. filed within 72 hours after 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Architect Private Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o P pe Harry James Kelley t. Page 1 and 2 should by thent of Health and Mertant: If item 27 is mark Patricia Lynne Yawn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanna W. Kelley/ Wife 1603 Sherwood Road, Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place June 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 2012 Burtonsville, MD Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. 22. Name and Address of Facility M01053 313 Talbott Ave., Laurel, MD\_20707 23a. 21 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myocardial Infarction Medical **Examiner** Hypercholesterolemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year g Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed plnods 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 2XXNo Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 X Yes 2 □ No ပ Other: 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day, Year) 1 X Natural 5 Pending work? Accident 1 Tyes 2 No filled in by the Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D67355 May 26, 2012 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 15V Daniel Kenneth 1500 Forest Glen Road, Silver Spring, MD 20902 Sherk, 32. Registrar's Signature State Registrar

12-04051 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 17138 Wesley Knight State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death Month Month Day May 28, 2012 **Medical Examiner** Wesley A. Knight 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 11211 Old Hopkins Road Clarksville Howard 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Davs Hours Director 427-63-8540 XX M 2 F 24 June 23, 1987 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
inportant: If item 27 is marked other than "natural", or items 23a no 28s-f-sho MD Howard Clarksville Director 10e. Street and Number 10f. Zip Code 11211 Old Hopkins Road 21029 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 2 No \_\_\_ Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done l other than "natul Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Student Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nent of Health and Mental Fiant: If item 27 is marked or other traumatic event, I æ Lawrence B. Knight, III Kimberly A. Gaillard 19a. Informant's Name/Relationship (Type, Print ) Lawrence B. Knight/Father 11211 Old Hopkins Road, Clarksville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State West Arundel Crem. 5/31/2012 Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 313 Talbott\_Avenue, M01103 Laurel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical a. Contact Gunshot Wound of the Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ending physician and use as the burial - transi Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 24a. Was an

oreign Mississipp Country) 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black White 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, Approximate Interval Between Onset and Death Records, P.O. Box 68760, The law requires that the death certificate be executed Day Year 23e. Did tobacco use contribute to the cause of death? icate has been signed by page 2 should be detach 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed 1 🗸 Yes Yes 2 No 2 No Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other. Scene DOA this 1 Yes No After 1 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject sho self \_\_ Natural FOUND: 5 Pending 1 Yes 2 ✔ No hours after death. the May 28, 2012 1802 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 11211 Old Hopkins Road, Clarksville, MD within 24 hours a determined (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registra

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ar	and hould see see see see see see see see see se		19a. Informant's Name/Relationship (7	ype, Print) Daughter	19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	er, City or To	wn, State, Zip C	ode)
Σ	alth alth 27 i		Mrs. Sharon L. B	aikauskas	204	Rock Rid	ge Road	Millers	sville	, MD 2	1108
<u> </u>	I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  If Health and Mental Hygiene.  If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	20b. PI	ace of Dispos	sition (Name of		Date	1	ation - City or To	wn, State
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inge	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	dge, death o	ccurred at the tim	e, date and place,	and due to the o	cause(s) and	manner as state	d.
<u> </u>	in 24	Mec	(Check 2 Medical Exam only one) 3 Certifying Num	iner: On the basis of examination se Practitioner: To the best of m	ana/or investi y knowledge,	gation, in my opinion death occurred at the second control of the	on, death occurred a the time, date and p	at the time, date lace, and due to	and place, ar the cause(s)	nd due to the cau and manner as st	se(s) and manner stated ated.
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			30. Name and address of person who	completed cause of death (Item :	23a) (Type. Pi	rint)	01		<u> </u>		
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Live Birth 2 Fetal death
Pregnant at time IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 2 No 1 🔲 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending injury s after death.

I Director: Aff Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1(Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) e and address of person vno completed cause 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month Physician/ Kammerer May 11:01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Hours Min 216-28-2656 1 □ M 2 **X** F **Director** 83 Yrs. Feb. 20 1929 NC Usual Residence of Decede or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Baltimore Cckeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 1106 Justa Lane 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? ģ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give white 3 X Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 11:01 12 n/a Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မ Elvers Brown Virginia Rae Frederick 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) be partment of Health a Important: If item 27 is any injury or a series of the series Janet Knight/sister 844 Carsins Run Rd., Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗀 Removal from State 27, 6/9/12cemetery, crematory or other placel Donation 5 Other (Specify) Dulaney Valley Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 Flagle 23a. Part 1. Enter the deease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death KAMMERER 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No
9 ☐ Unknown Month Day Year 5 Other (specify) Pregnant at time of death has been signed by the a le 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an , page 2 autopsy To the Hospital or Attending Physician: The Ewithin 24 hours after death.

To the Funeral Director: After this certificate h Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending 2 🗆 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Physician/ Mai Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Montagnery Run toward Ellicott 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Unde **Funeral** 212-58-6993 **Director** 1 M 2 X F 63 12-21-1948 Maryland 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Ellicott City Howard 1 Yes 2 XXIo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 United States 8378 Montgomery Run Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. by 1 X Never Married 2 Married Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) be filed within 72 Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Government marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo Kosh Helen Carroll 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8378 Montgomery Run Rd., Ellicott City, MD 21043 Monique Mathis - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date Cremation 3 🗋 Removal from State 1XXBurial cemetery, crematory or other place) 5 Other (Specify) Meadowridge Mem Park | 05-26-2012 Elkridge, Maryland 4 Donat 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Er shock, o ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ ovarian cancer disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** heeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Records, 1 Yes 2 No 3 Probably Completed Were autopsy findings available prior to completion of cause of 24a. Was an has , page 2 autopo, performed 2 j death? 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Deal Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number Medicina amilu D00061396 me and address of person who completed cause of death (Item 23a) (Type, Print) Forest Road Scute 102 Columbia MD 21046 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Рм May 23 5:10 Mattie E. Keith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Charlestown Care Center Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Hours 225-12-4184 Director 1 🗆 M 2 🔀 F 11/17/19 92 Virginia Usual Residence of Decede 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 28a-f 1 Yes 2 No MD Catonsville Baltimore or 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ms 23a or must be r Funeral 703 Maiden Choice Lane Apt. 7812 21228 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed the and Mental Hygiene.
It is marked other than "nature traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Western Auto Supply Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Peter Edward Woodruff Carrie Jane Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other traconce. B. Diann King Daughter 8 Morgans Turn Ocean View, Delaware 19970 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Baltemore to Crematory 1 Burial 2 S Cremation 3 Removal from State 4 Donation 5 Other (Specify) @ Loudon Park 5/25/12 Baltimore, Maryland Signature of Funeral Service Line 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 uc implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. Liston Immediate Cause (Final Onset and Death Priysician/ Due to (or as a co o quence of) Cance craf disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months? jo Month Day Year Pregnant at time of death 5 Other (specify) the hed 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 page 2 certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Natural 24 hours after death. Funeral Director; A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, þ 4 Homicide determined City or Town, State) filled in Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. letely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RIUS 2

State Registrar den Choice In. Catensville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State	State of	iviaryian	•			l Mental Hy	giene		1
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s 23a	<b>Funeral Director</b>	2301 Whitby C	ourt			21228			USA		
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifyi (Check 2 Medica	ing Physician: To the bes	t of my knowle of examination	edge, death of	occured at the time	e, date and place, on, death occurre	, and due to the ca	use(s) and ma	anner as state	d. ise(s) and manner stated.
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician/ 2:53 AM 29 ane 20/2 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Cent altimore lizabeth Wing 9. Birthplace (State or Foreign 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day Year) 934 Min 1 ☐ M 2**XX** Maryland Director 219-30-4162 77 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 😾 Yes 2 🗆 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21227 3320 Benson Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🎦 No Specify: White 3 🛱 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12 Purchasing Agent Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Anna Marie Spivey Richard Von Mabius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, MD 21043 5250 Carson Court (Son) Richard Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5-31-2012 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Witzke Funeral Homes, Thele Columbia, MD 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus up each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ been signed by the atte in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe .24 hours after death. e Funeral Director: After this certificate bettered filled in by the funeral director, pag 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Certificate: injury work? 1 🔲 Yes 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invasitable. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 30. Name and address of person who compared ted cause of death (Item 23a) (Type, Print) 10V

State Registrar Ming

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mar 11:07 PM Medical Facility Name (if not institution, give street and number City, Town, or Location of Death 4c. County of Death **Examiner** OURS MD timore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Hours Min. (Month, Day, **Director** 137-52-5408 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits notified at rector Newark 1 Tes 2X No N.IEssex ā 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ems 23a or r must be r Funeral U.S.A. South Eleventh Street er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Completed 3 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ementary/Seconday (0-12) College (1-4 or 5+) 11th grade Disabled Disabled na other permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carter Smith Arthur Mae Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Lowe-Wife 673 S. Eleventh St, Newark, NJBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Date 20c. Location - City or Town, State cemetery, crematory or other place) Ever Green 6/4/2012 Hillside, NJ 22. Name and Address of Facility March F/H West 4300 Wabash Av ral Sen Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and deetached for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has perform 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2·No Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5  $\square$  Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type MASNE DUNGVAN Muse State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Frances Ann Ladner 2012 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 24, 2012 1140 hrs Medical Examiner Frances A. Ladner c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Pasadena Anne Arundel 721 204th Street If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Hours Director 52 11/15/1959 Martyland 220-72-1433 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No Anne Arundel Pasadena permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ar items 23a nr 28a-f shu injury ar other reaunalte event, the Medical Examiner must be notified at once. Director 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21122 721 204th Street 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes Specify: White 1 Yes 2 No specify: 4 Divorced If Yes, Give Year ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Dog Walker Self Employed 2 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Egan Be Eugene DiPeppe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 7953 Tamoshanter Glen Glen Burnie, MD. 21061 Gina M. Zinn Daughter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/30/12 Baltimore, Maryland Loudon Park Cemetery 4 Donation 5 Other Specify 22. Name end Address of Facility 21. Signature of Funeral Service Licenses Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enjer the disease, or failure. List only one caus **Physician** Between Onset and Medical Death aHeroin and Cocaine Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, 28a-f, per me, g928 6-4-12 sm **▼** UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c, If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Yea 3 Ectopic pregnancy Day 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) 27. Manner of Death Certification: 1 Natural 1 Yes 2 X No unknown 5 Pending fd 5-24-12 fd 11:30 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 721 204th St. Pasadena, MD. - At home, farm, street, factory, office building, etc. 28e. Place of Injury 3 Suicide 6 X Could not be Residence determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** (Check only 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie May 25, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Region 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. C:50 PM State of Maryland / Department of Health and Mental Hygiene For State Registrar 5/25/2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05/25/2012 Physician/ Betty Jean Laster 5:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges St. Thomas More Hyattsville 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - F 01911-29 1999 62 578-68-4509 DC **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important; If item 27 is marked other than "---- any injury or other than" 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Columbia 1 X Yes 2 □ No Washington, DC DC District of 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20017 4524 6th Place, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 MNo Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeanette Jackson John Henry Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc A. Lewis son 4524 6th Pl., NE Washington, DC 20017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖰 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Ft. Lincoln 6-08-2012 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W.H. Bacon Funeral Home Wanda 3447 14th St., NW Washington, DC 20010 CC0361 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Carisiovas was Ph\_sician/ MITERIOSCLEROTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Examiner Due to forces a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖾 No 5 ☐ Other (specify) Month Day Year 9 Unknown ed by the Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Chronic Obstructive Lung Disease Pulmon anythypententian 1 Kres 2 No 3 Probably 4 Unknown Completed Obstructue Sleep aprica Morbid Obesity 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Congestue Heart Failure performed 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA After this thin 24 hours after death.

the Funeral Director: After thi
mpleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation ☐ Accident ☐ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2, To the F complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 25 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4208 Queensbury Rd Hyattsville M)20781 31. Date filed (Month, Day, Year NAY 3 1 2012 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year Months Days 4 Hrs. Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, **Director** 1 M 2 F xouth care In , or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City, Limits **Funeral Director** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 000 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) partmen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Sumame) ပ 19a. Informant's Name/Relationship (Type, Print) (Nephew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S te, Zip Code) a 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of June al Service Licensee Itom uss Dr Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Enter the Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical disease or condition resulting in death) TO scom Due to (or as a con equence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a cor Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery ☐ Ectopic pregnancy Month Day 5 Other (specify) Pregnant at time of death ed by the a detached g | Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury work? 5 Pending 2 No Accident Investigation 24 hours after deal Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year, MD 31464 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. HASHMIMD Suite 308 BALTIMORE MP 821 N. EUTAW St. 31. Date filed (Month, Day, Year) State 32. Registra 's Signature MAY 3 1 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:10 PM Evan Preston Maynard, Jr. May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4108 3rd Street Apt. #106 North Beach Calvert Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec • 19 **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 1 M 2 □ F Min. Hours West Virginia 232-70-4255 **Director** Dec. 67 1944 Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Calvert North Beach 1 X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4108 3rd Street Apt# 106 20714 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black. White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 👿 No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Specialist Tele-Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evan Preston Maynard, Sr. Emma Waycaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Daniels - Daughter 16982 Prince Frederick Rd, Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 1,2012 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Davidsonville, MD <u>Memorial Gardens</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any handing to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Unknown 1 Yes 2 No 9 Unknown cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HY PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CORUMARY ARTERY DISTAGE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv After this certificate 2 No 1 🔲 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🗌 No Other: ျပ 1XXYes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practions ed at the time, date and plane, and due to 29b. Signature and title 29c, License number 29d. Date signed (Month, Day, Year) 5/30/12 D37064

Registrar

DHMH 17 Rev 7/2009

State

Yueenstown, mD

e and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 3 1 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:07 A.M Physician/ 2012 Irene M. Meyer May 30 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1220 Armacost Road Parkton If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) Hours Min 220 24 5697 1 🗆 M 2 🎛 F 85 Director 09/01/1926 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov aţ Director ms 23a or 28a-f s must be notified 1 🗆 Yes 2 😾 No Baltimore Parkton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death with 21120 1220 Armacost Road ral", or items 2 Examiner mus 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black White etc. Armed Force þ 1 Never Married 2 X Married Yes 2 x No Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Beautician Self Employed 12th traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental I ဂ Mary Demchuk Phillip Demchuk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parkton, Maryland 21120 Johannes Meyer / Husband 1220 Armacost Road item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 06/02/2012 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ADRTIC STENOSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate
Finter Underlyin
Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death
9 Unknown 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Ohstructure 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30/12 1)26637 who completed cause of death (Item 23a) (Type, Print) 30 Name and address of per-TOWSON, MD lov 311 Registrar's Signa 31. Date filed (A

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Morisi Joann M. Year Physician/ 2012 2:50 A May 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Gilchrist Hospice Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth Funeral Days (Month, Day, Year) Hours Min. Director 216-24-7922 1 M 2 X F Yrs 84 Ohio 4,1928 April Usual Residence of Deced 28a-f shov 10b. County 10c. City, Town or Location 10a, State the Medical Examiner must be notified at death with the Maryland Director 1 Yes 2 X No Dundalk Baltimore MD 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral 23a1809 Dunmere Road United States 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 5 1 Never Married 2 Married φ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annabell Dennis မှ Albert R. Paglia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 1809 Dunmere Road Dundalk, Maryland (Husband) Paul J. Morisi 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland Gdns.5/29/201 Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Michael 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Neiser Dundalk, Maryland Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Draw to for es a consequence of: Examir Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE Se If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day 5 Other (specify) is certificate has been signed by the a director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA this ( s after death.

I Director: After this ad in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after
To the Funeral Directory Medical 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) D71040 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address RALTIMORE 6701 RUITE MD FRATHT 4105

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07:02 PM 2012 Medical 4a. Facility Name (if not institution, give street and number 4b City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL OF BALTIMORE BALTIMORE Cl If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 213-26 **Director** 1 □ M 2 🗸 F 29 MD 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** must be notified MD1 Yes 2 No ti more 10e. Street and Number ö 10g. Citizen of What Country? 21217 23a IJSA Hvenue items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DΦ NOT use re ired) Il Hygiene. Coffege (1-4 or 5+) Elementary/Secondary (0-12) leache Be atient known as 17. Father's Name (First, Middle, Last) er's Name (First, Middle, Maid and Mental His marked of မ Informant's Name/Relationship (Type, (rithaughter) e, Zip Code)21213 19b. Mailing Admess (Street and Number City or Town. St. f Health aitem 27 i baltimore t: If item or other 20a. Method of Disposition 20b. Place of Dispositi Burial 2 Cremation 3 Removal from State Important: If any injury or 2012 4 Donation 5 Other (Specify) nature of Funeral Service Licenses Vа smore Nat 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ gasteric disease or condition resulting in death) Medical Due to (or as a consequente 4f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No the page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 29,2012 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimose State egistrar's Signatu Registrar

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036	should be filed within 72 hours after death with the Maryland nand Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ρ	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates.	lo		Yes, specify Cuban, M		o Rican, etc.)	- 1	Black, White, ecify: B1	
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Baltimore,	Page nent o ant: If ury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State (y)		netery, crem n–Si	atory or other place)	5/30	/2012	1		
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	To t To t		29b. Signature and title of certifer	MB,BS			29c. License nun			29d. Date sig May, 22	gned (Month, ,	Day, Year)
			30. Name and address of person who could be a second of the country of the countr	ompleted cause of dea	th (Item 23	3a) (Type, Pr	OF BALTIM	ORE				
	Stat Registra	e	31. Date filed (Month, Day, Year)	32 Registrar's	Signatur	ho	ve)					
DU	MH 17 Rev 7/20		0 = 50	No partie	70.	7				<del></del>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 30 Laura V. Morningstor 0810 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bultimure Washington Medical center 6 Ich Barnic Arnadel Anne 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year Director 213-30-8424 1 🗆 M 2 😿 F 12/24/32 Maryland show aţ 10a. State 10c. City. Town or Location 10d. Inside City Limits Director must be notified MD 28a-f Anne Arundel Co. Glen Burnie 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7976 Cross Creek Drive 21061 United States ral", or items ! 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 ₩idowed 4 □ Divorced "natural", Completed Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic security. Elementary/Secondary (0-12) College (1-4 or 5+) Assembler Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morningstar ဂ္ John R. Stolt Cynthia Ε. Hobbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara A. Hamilton/Daughter 7976 Cross Creek Drive Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 06/02/2012 Glen Burnie, MD Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Acute Fuilare on chrunic Kidney Kidney disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Myocardial Inforction Non- ST elevation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam Metabolic aciolosis that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has autopsy performed? Yes 2 No After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 \( \sum \) Yes 2 \( \sum \) No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🔲 No Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director: A

completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D0668123 30,2012 Novauc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Glen Burnel 301 Hospital

Registrar
DHMH 17 Rev 06-2011

State

DANICA DONCIC

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 17156

		1- For State Registrar			Ce	ertificate (	of Dea	ath			R	leg. No	).		
Physic		1. Decedent's Name (First, M	iddle,Last)								Date of Dea     Month				3. Time of Death
/ledical Exam	iine	CLEASON SHAWN		<del> </del>			T ::				May 24, 2	2012			0410 hrs
Was .		4a. Facility Name (if not institute 12859 Vansant Co			·)			r, Town, oi nedyvil	r Location o	of Death			c. County of Kent	Death	
Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs.	last birthday)		nder 1 Yea		er 24Hrs.	8. Date of Bi	rth(MN	1/DD/YYYY)		nplace (State or Foreign intry)
Director		162.78.5098		4 2 F		14 Y	rs.	iths Day	ys Hours	Min.	AUGUST	29,	1997	COL	PA
any	1	Usual Residence of Deceder  10a. State 10b. Cou			10c City	, Town or Loc	ation								40d facida Ot Limita
<b>*</b>	١.		•											İ	10d. Inside City Limits  1 Yes 2 XXNo
Aaryland 28n-f show Lat once.	용	PA LANC 10e. Street and Number	ASTER		PEAC	H BOTTON		Zip Code				On Ci	tizen of Wha		
th the Maryland 23a or 28a-f sho notified at once.	Director	989 GOSHEN MI	11 00									og. Ci		it Coun	try?
with t 1s 23a		11. Marital Status		12. Was Deceden	t Ever in U	J.S. 13. V		17563 dent of His	spanic Orig	in? ( Sp	ecify Yes or No	)-	USA 14 Race -	Americ	an Indian, Black,
death rr iten	Funeral	1 XX Never Married 2	Married	Armed Forces 1 Yes 2	? XX No	If	Yes, spe	cify Cubar	n, Mexican,	Puerto I	Rican, etc.)		White,		, 5,550,
after al", o	by F	3 Widowed 4	C	Yes, Give Year or Dates:		1	Yes	2 XX No	specify:				Specify:	WH	ITE
hours matur	eted	15. Decedent's Education (				16a. Decede			tion (Give k			16b.	Kind of Busi	ness/In	ndustry
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin	를	Elementary/Secondary (0-	2)	College (1-4 or	5+)						-,			=	
d with	Compl	9 17. Father's Name (First, Mid	die, Last)			<u> </u>	FAF	RMER	18 Mother's	s Name	(First, Middle, I	Maider	FARM11	1G	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical	Be	GLEN W. NOLT									. MARTIN	Maido	rouniuno		
21 hould is man	2	19a. Informant's Name/Relati	nship (Typ	e, Print )		19b. Maili	ng Addre	ss (Stree			ural Route Nur	nber, C	City or Town,	State,	Zip Code)
ire, MD 21215-0036  Is land 2 should be filed within 72 hours after death with the Maryland of Health and Mhorall Hygiens  If tirem 27 is marked other than "natural", or items 23a or 28a-f 5he over traumatic event, the Medical Examiner must be notified at once		DEBBIE H. NOLT		MOTHER						PEACH	BOTTOM,				
		20a. Method of Disposition  1 XXBurial 2 Crema	tion 3	Removal from St		Place of Dispo crematory or o			metery,		Date	20c.	Location - C	ity or T	own, State
time Pag tment tant:		4 Donation 5 Other	Specify:		BE	THEL MEN					8.2012		ARRYVIL	-	
Baltimore permit. Pages I Department of F Important: If injury or other		21. Signature of Funeral Serv			M0114	22. F	Name an INK F	Id Address UNERAL	s of Facility HOME,	P.A	. t/a MAF BURNIE, N	RYLA	ND MORT	UARY	SUPPORT
Physician		23a. Park Enter the disease failure. List only one cau	or complica	ations that caused	the death	Do not enter	the mode	e of dying,	such as ca	ardiac or	respiratory arr	est, sh	ock, or hear		Approximate Interval
/Medical Examiner		Immediate Cause (Final disea	$\sim$ .	ultiple Injuries	3										Between Onset and Death
		or condition resulting in death	) Du	ie to (or as a cons	equence o	of):									
	Jer	Sequentially list conditions, if any, leading to immediate		e to (or as a cons	equence o	of):				_				$\dashv$	
	Examiner	cause. Enter Underlying Cau (Disease or injury that initiate	C.	e to (or as a cons										_	
uted ad ransit		events resulting in death) La	,t d.	le to (or as a cons	equence o	n):									
760, icate be executed physician and the burial - transit	ledical	UNPENDED		AMENDED					-			-		一	
Box 68760, death certificate be he attending physicil of for use as the buri	₹	IF FEMALE: 23b. Was decedent pregnant in	the	23c. If yes, outcome	ne of preg	nancy	_					23	d. Date of de	elivery	
certif	cian	past 12 months?		1 Live birth 4 Pregnant at	time of de	oth	etal death		Ectopic	pregnan	су		Month	Da	y Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9	Inknown I	9 Unknown		2 0	ther (Sp	есту)			-	1163			
Division of Vital Records, P.O. Box 68 To the Hospital Acteding Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant con	ditions co	ontributing to deat	h but not r	esulting in the	underlyir	ng cause g	given in Par	t I.					ne cause of death?
S, P											1 Yes	2 🗸	No 3	Proba	bly 4 Unknown
ord w requires peed should	Completed										24a. Was a autop				psy findings available mpletion of cause of
Rec The la	E										perfor		provide the second	ath? Yes	2 No
tal Fisian:	Be	25. Was case referred to med examiner?						26.Place	of Death (0	Check or	nly one)				
Physic al dire	To	1 ✓ Yes 2 No	Hos		nt 2	ER/Outpatien					Home 5	Reside	ence 6 🗸	Other:	Scene
ding J	ü	27. Manner of Death  1 Natural 5 Pe		28a. Date of Inju (Month, Day, Y FOUND:	iry ear)	28b. Time of FOUND:	Injury		ry at Work?	l n	28d. Describe h				
Sional Atten	cati		ending vestigation	May 24, 2012	!	0410 hrs	-1 (1		res 2 1		,				
Division of Vital Records, pital of Attending Physician: The law require ours after death.  eral Director: After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	de	ould not be termined	28e. Place of In			et, ractor	y, office b	uilding, etc.	1	or Town, S 2859 Vansar	treet a	and Number	or Rura	I Route Number, City
Hospi 4 hou Funer ely fil		4 Homicide  29a. Certifier 1 Certifying	Physician	To the best of m			rred at th	e time da	ato and place		· <del></del>	_			
Division  To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	one) 2 Medical E	xaminer: Or	n the basis of exa	mination a	nd/or investiga	ation, in m	ny opinion,	, death occi	urred at	the time, date	e(s) an and pla	ace, and due	to the	cause(s)
E.≱ E. 8	Me	29b. Signature and title of cert		nd manner stated.			29	9c. License	e number			29d.	Date signed	(Mont	h, Day, Year)
		(and	4101	Q de m				O.C.N	M.E.			May	/ 24, 2012	2	
	ł	30. Name and address of pers				,									
		Carol H. Allan, MD		ant Medical E			Baltimo	ore Stre	et, Baltin	nore, l	MD 21223				
St Regist	ate rar	31. Date filed (Month, Day, Yea	1 2012	32. Registra		1. Ja	No	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03939 State of Maryland / Department of Health and Mental Hygiene Kelvin Roy Nolt Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day May 24, 2012 Physician/ 0537 hrs Medical Examiner KELVIN ROY NOLT 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Kent Kennedyville 12859 Vansant Corner Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funerai Months Days Hours PA **Director** MARCH 14, 1994 Yrs 1 X XM 2 18 201.74.1377 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State 1 Yes 2 XX No PEACH BOTTOM 28a-f show s 23a or 28a-f show e notified at once. LANCASTER mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f cho. PA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 17563 989 GOSHEN MILL RD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White, etc. Armed Forces? Married 1 XNever Married WHITE Divorced If Yes, Give Year Yes 2 XX No specify: Widowed ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) or other traumatic event, the Medical 21215-0036 FARMING FARMER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DEBBIE H. MARTIN Be GLEN W. NOLT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 989 GOSHEN MILL RD. PEACH BOTTOM, PA 17563 Baltimore, MD DEBBIE NOLT MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Oisposition crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State 5.28.2012 QUARRYVILLE, PA BETHEL MENONITE CEMETERY Donation 5 Other Specify 22. Name and Address of Facility gna re of Funeral Service L. Fns. e FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. GREGORY FIN M01148 Approximate Interval 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death /Medical a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician/Medical **AMENDED** UNPENDED attending physician or use as the burial -The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I Part II. Other significant conditions o Yes 2 V No 3 Probably 4 ģ σ. Completed 24b. Were autopsy findings available 24a. Was an Division of Vital Records, prior to completion of cause of autopsy death? performed? has ✓ Yes 2 No 1 🗸 Yes this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 Inpatient 2 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury FOUND: 28b. Time of Injury 27. Manner of Death Precipitated into manure pond Certification: FOUND 1 ✓ Yes 2 No Natural Pending May 24, 2012 0537 hrs 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by or Town, State) 12859 Vansant Corner Road, Kennedyville, MD Could not be Suicide determined (Specify) manure pond Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 24, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**OCME** 

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ilen Webster N		State of Maryland / Department of Certificate of		d Mental Hy		. No. 2 (	112 1715
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)			2. Date of Death	in the time to	3. Time of Death
Medical Exami		GLEN WEBSTER NOLT			Month May 24, 20	Day Year 12	0122 hrs
		4a. Facility Name (if not institution, give street and number) 12859 Vansant Corner Road	4b. City, Town, or L Kennedyville			4c. County of Kent	Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year		8. Date of Birth	(MM/DD/YYYY)	Birthplace (State or Foreign Country)
Director		210.64.5119 1XXM 2 F 48 Yrs	Months Days	Hours Min.	MARCH 7	, 1964	PA
	ļ	Usual Residence of Decedent	<u> </u>				
w any		10a. State 10b. County 10c. City, Town or Local	ion				10d. Inside City Limits
land f sho	ĕ	PA LANCASTER PEACH BOTTON					1 Yes 2 XX
Mary r 28a- ed at	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of Wha	t Country?
ith the Maryland 23a or 28a-f show a notified at once.		989 GOSHEN MILL RD.	17563			USA	
th wi	Funeral		as Decedent of Hisp es, specify Cuban,			14. Race - White,	American Indian, Black, etc.
er dea	Œ	1 Yes 2 XX No 3 Widowed 4 Divorced If Yes, Give Year	Specify:	bull TC			
irs aft ural"	ē	l or Dates:	Yes 2 XX No		ork done	16b. Kind of Busi	WHITE ness/Industry
2 hou "nat	ě		nost of working life.				,
thin 7 re. than tedica	힐	10	FARMER			FAR	MING
5-0 ed wi tygies other	Completed	17. Father's Name (First, Middle, Last)	1	18.Mother's Name	(First, Middle, M	aiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	MARTIN Z. NOLT		EVA M. W			
D 21 hould and Me is ma	욘	3.4/	g Address (Street				State, Zip Code)
MD and 2 sho allth and 27 is m 27 is aumat		DEBBIE H. NOLT         WIFE         989 C           20a. Method of Disposition         20b. Place of Disposition	OSHEN MILL				city or Town, State
of He		1 XX Burial 2 Cremation 3 Removal from State crematory or of	ther place)				•
Pag Pag ment tant: or of		4 Donation 5 Other Specify: BETHEL MENO			8.2012	QUARRYVI	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Spinature of Funeral Service Lizenset 22. Fi	NAME and Address NK FUNERAL	HOME, P.A	. t/a MARY	LAND MORT	UARY SUPPORT
	-1	K. GRECORY FINK M01148 42 23a. Part Enter the disease, or complications that caused the death. Do not enter	6 CRAIN HW	Y SW GLEN	RONIE, MD	21061	
Physician /Medical		failure. List only one cause on each line.	, 0,				Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):					
		Sequentially list conditions, b					
	ner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause					
	Examiner	C. Due to (or as a consequence of):					
uted nd ransit	ĕ	d.					
50, te be executed ysician and burial - transit	edical	UNPENDED AMENDED					
760 icate t	₩.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	. [			23d. Date of d	
certificate	sician/M	past 12 months?	etal death 3 ther (Specify)	Ectopic pregna	incy	Month	Day Year
Box 6876C he death certificate the attending phys hed for use as the bh	ysi	1 Yes 2 No 9 Unknown 9 Unknown	mer (opeary)				
P.O.	y Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause g	given in Part I.	,		ute to the cause of death?
cords, P.O.  Taw requires that the bas been signed be detailed.	d by				1 Yes	2 <b>V</b> No 3	Probably 4 Unknown
v request should	Completed				24a. Was a autops		ere autopsy findings available or to completion of cause of
ecc he lav ate ha	E O				perform		ath? ✔ Yes 2 No
Division of Vital Records, ral or attending Physician: The law requir 1s after death.  In Director: After this certificate has been s led in by the funeral director, page 2 should I	Be C	25. Was case referred to medical		of Death (Check	only one)		
Vit hysici this c	0	examiner? 1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA	Other Nursin	ng Home 5 F	Residence 6	Other: Scene
n of ding Ph	n: T	27. Manner of Death  28a. Date of Injury POWND: Day, Year)  28b. Time of FOUND: FOUND:		ry at Work?		ow injury occurre into manure i	
ivisior or Attend after death Director:	ätic	2 Accident Investigation May 24, 2012 0122 hrs		Yes 2 No		<u>'</u>	
ivis after after Dire	Certification:	3 Suicide 6 Could not be determined (Specify), manufactory and street determined (Specify).	et, factory, office b	ouilding, etc.	or Town, St	ate)	or Rural Route Number, City
ospita hours ineral		4 Homicide (Specific					Kennedyville, MD
Division of Vital Records, P.O. Box 6876. To the Hospital or detending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	one)  Certifying Physician: To the best of my knowledge, death occurrence  Medical Examiner: On the basis of examination and/or investigation.					
To To	Med	and manner stated.  29b. Signature and title of certifier	29c. Licens	e number		29d. Date signe	(Month, Day, Year)
		Course Landan.	O.C.I			May 24, 201	
		30. Name and address of person who completed cause of death (Item 23a)				., ., .	
		Carol H. Allan, MD Assistant Medical Examiner 900 W.	Baltimore Stre	eet, Baltimore	, MD 21223		
S	tate	31. Date filed (Month, Day, Year) 38. Registrar's Signature		-			
Regis	trar	MAY 3 1 2012 Serve S. Jan	100				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First\_Middle\_Last) 2. Date of Death Physician/ 24 Day 2012 Year MAY JAMES HERBERT 8:54 A M NEAL SR. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCREST HOSPICE COLUMBIA HOWARD Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 577-62-2442 Director 1 🗶 M 2 🗆 F 63 SEPT. 11 1948 WASHINGTON, DC Usual Residence of Dece show 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits rector notified ANNE ARUNDEL MD ODENTON 28a-f 1X Yes 2 □ No ā ms 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2298 INDIAN SUMMER DRIVE 21113 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ò ģ 1 Never Married 2X Married Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify "natural", Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Il Hygiene. College (1-4 or 5+) 12TH MOTOR VEHICLE OPERATOR GOVERNMENT event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H
27 is marked of
r traumatic ever ၉ JAMES HERBERT NEAL MARY M. YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health : 2298 INDIAN SUMMER DRIVE ODENTON, MARYLAND 21113 RUTH SYLVIA NEAL/WIFE altimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from State ò Department Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) HILL CEMETERY 6/01/2012 SUITLAND, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Waphner N LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 7474 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ears Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence on Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and is the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ģ in the past 12 months? Day Pregnant at time of death 2 No ate has been signed by the a page 2 should be detached to 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Tena 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital 2- No Other: Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No the f 2 Accident
3 Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0060631 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

JOSE

1 2012

31. Date filed (Month, Day, Yea

6336

32. Registrar

CEPAR

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:0A M Physician/ Month Machia awrence 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FEDERAL ST BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours (Month. Day. 224-26-8620 Director 0 10 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director BATTMORE MD 1 XYes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral USA FEDERAL 21213 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Bethlehem Steel Elementary/Seconday (0-12) College (1-4 or 5+) TRackman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Oliver Josephine Jennings 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) 19a. Informat's Name/Relationship (Type, Print) WIFE E. Federal St. BALTO MO. illie 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 18/2012 GARRISON FOREST BACTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) GREENE FUNERAL SCX Signardre of Funeral Service Licenses no YORK DAD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nolos carrier Ph, si ian/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has this certificate 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 5  $\square$  Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 the only one) 29h. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) 39,2012 D40854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St PAJI PI Bultinon MD 21202 (M) Kiseboz Direct 227 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

			For State	State of Maryland / I			Mental Hy	giene	
			Registrar		Certificat	e of Death		Reg. No. 2	2 7 6 1
	Physicia Medio		1. Decedent's Name (First, Middle, Last)  Ellsworth Par.	KEL			2. Date of Dea	Days 2012	3. Time of Death  10 3 5 A M
	Examin		4a. Facility Name (if not institution, give stre	eet and number)	4b. City,	Town, or Location of Death	=	4c. County of Dear	IMORE
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. last birt	Months		8. Date of Birt	h 9. Bir	thplace (State or Foreign
	Director ≥		217 - 62 - 1629 12 Usual Residence of Decedent	59	Yrs.		3 3 1	1933 I M	ary land
	aryland a-f sho iled at	Director	10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Ma or 28s	Dire	10e. Street and Number	More	10f. Zip	SVIII Code		10g. Citizen of What Co	
	ms 23s	Funeral	1 Sudbrook	Lane	10 Wee Deep	21208	soifu Van av Na	US/	4
စ္က	fter dea , or ite aminer	by	1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give	If Yes, spec	dent of Hispanic Origin? (Sp. cify Cuban, Mexican, Puerto 2 No Specify:	Rican, etc.)	14. Race - Ame Black, Whit	
00	nours a natural' ical Ex	eted	3 ₩ Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates.	a. Decedent's Usu			Specify: 16b. Kind of Business	Industry
21215-0036	hin 72 l ne. <b>than "r</b> te Med	Completed	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)		rk done during most of wor	king	C 10 C	a la
	filed wit Il Hygie I other vent, th	Be	17. Father's Name (First, Middle, Last)		Linen	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	to shot
Maryland	uld be 1 I Menta narked natic e	ည	James A.	Parker		Iren	e E	. Cran.	
Ma	d 2 sho alth and 27 is r er traun		19a. Informant's Name/Relationship (Type,	/\	- 2 ~ 2 1 1	S(Street and Number or Ru	Ant.	r, City or Town, State, Zi	o Code) 21201
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place o cemete.	of Disposition (Nar ery, crematory or o	ne of	Date	20c. Location - City of	
altim	nit. Pag bartmen bortant injury	-	4 ☐ Donation 5 ☐ Other (Specify)  21. Signatury of Funeral Service Licensee	Bayv	iew Cre	matory (6)	120121	Dundall-	4 MD
ä	Depar Impor any ir		Faulle H.	Spacering J. 4h	222	PW. Wort	L'Ave.	Baito, K	ND 21216
1	Physician/		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of immediate Cause (Final	ations that caused the death. Do recause on each line.  RENAL FAIL	,	le of dying, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence					> S YEARS
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):				
	and transit	Examiner	Cause. Enter Underlying Cause (Disease or inique) that initiated events c. resulting in death) Last	Due to (or as a consequence	oft:				
09	icate be executed physician and s the burial-transit	edical E	d.	Due to (or as a consequence of	01).				
	artificate ding phy se as the	/Med	IF FEMALE:	If yes, outcome of pregnancy				1	
Box 687	leath certifica e attending p d for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal deatl  4 ☐ Pregnant at time of death	th 3 Ectopic 5 Other (sp			23d. Date of de Month	livery Day Year
0	at the d d by the letache	Phys	9 Unknown  Part II. Other significant conditions contri	9 Unknown	in the underlying	cause given in Part I.	23e Did to	obacco use contribute to	the cause of death?
Division of Vital Records, P.O.	requires that the de been signed by the should be detached	ed by	HIV/AIDS						Probably 4 Unknown
cor	law req has bee e 2 sho	nplet	DIABSTES				24a. Was	osy prior to	rtopsy findings available completion of cause of
al Re	sician; The law certificate has t lirector, page 2 s		HYPSITENSION 25. Was case referred to medical			26. Place of Death (Che	1 🗌 Yes	rmed? death? 2 No 1 Ye	s 2 🗆 No
<b>Zit</b>	hysicia nis cer I direct	To Be	examiner? 1  Yes 2 No	spital: 1	utpatient 3 🗆 D			dence 6 Other (Spec	cify)
n of	ding P th. After tl funera		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		Time of injury M	8c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe h	now injury occurred	
visio	r Atten ter dea irector: I by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			28f. Location (S City or Tow	Street and Number or Ru	ıral Route Number,
Ö	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours atter death.  To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physici	an: To the best of my knowledge,	death occured at	the time, date and place.			ated.
	the Ho hin 24 h the Ful	Medical	(Check 2 Medical Examiner	: On the basis of examination and/o	or investigation, in	my opinion, death occurred	at the time, date a	and place, and due to the	cause(s) and manner stated.
	or vit		29b. Signature and title of certifier	24.15	290	License number		29d. Date signed (Mont	_
	•		29b. Signature and title of certifier  30. Name and address of person who com  XANUSSW C. JAMA  31. Date filed (Month, Day, Year)  NAY 3 1 2012	pleted cause of death (Item 23a)	(Type, Print)	/ .		May 72	·
	Sta	6	KANUSN C. SIAMI 31. Date filed (Month, Day, Year)	32 Registrar's Signatur	h Nomus	prunimans, M	oryland	21209	
	Registr		MAY 3 1 2012	ann p.	gara				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Day Andrew Lee Parks 0.3 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death the Loice Solisbury Hospice est Coastal wicamica Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 212-28-1306 1 ☑ M 2 □ F 81 July 23,1930 Usual Residence of Deceden Virginia 27 is marked other then "natural", or items 23e or 28e-f show treumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30440 Daphne Lane 21853 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Armed Forces?

1 ☐ Yes 2 【 No If Yes, Give Year or Dates. ģ 1 Never Married 2 XMarried Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Steel Worker Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ! is marked o 9 Emmit Lee Parks Nancy Virginia Anders 19a. Informant's Name/Relationship *(Type, Print)*(Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 sh Department of Health as Importent: If item 27 is any injury or other treu Mrs. Dorothy Lee Parks 30440 Daphne Lane Princess Baltimore, Anne. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 6/2/2012 Middle River, MD 21. Signature of Funeral Service Licensee Park WILLIams 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final LUNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): signed by the attending physician and dbe detached for use as the burial-transit Hospitai or Attending Physician: The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signed page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed No within 24 hours after death.

To the Funerei Director: After this certificate I completely filled in by the funeral director, pag 1 Ves ARNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & 1 🗌 Yes 2 No ဂ္ 105PIGZ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 8c. Injury at work? 28d. Describe how injury occurred 4-PNatural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 WARY 31. Date filed (Month, Day, Year) State Registrar

12-04018 Olivia S. Palmer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of Dea	nth		Reg		2 1/10
Physicia Medical Exami	an/	Decedent's Name (First, Middle	e,Last) Olivi	a S. E	Palmer		Mo	ate of Death onth I ay 27, 20	Day Year 12	3. Time of Death 1148 hrs
)		4a. Facility Name (if not institution Johns Hopkins Hospita				, Town, or Location of imore			4c. County of Dea	
Funeral Director		None	6. Sex 7. Age (I	n yrs. last birt	hday) If Un Mon Yrs.	ths Days Hours		Date of Birth 11/20/	(MM/DD/YYYY) 9. B /2011 Fore	irthplace (State or ign ountry Maryland
Maryland 28a-f sbow any 1 at once.	,	Usual Residence of Decedent  10a. State 10b. County  MD	10	c. City, Town	or Location	Baltimor	e			10d. Inside City Limits 1 XX Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once	Director	10e. Street and Number 1639 E. Cold	Spring Lane,	1st F		21218		100	. Citizen of What Co USA	untry?
hours after death with the Maryland 'natural', or items 23a or 28a-f sh Examiner must be notified at once	y Funeral	11. Marital Status 1 X Never Married 2 Ma 3 Widowed 4 Divo	12. Was Decedent Ev Armed Forces? 1 Yes 2	,	If Yes, spe	dent of Hispanic Orig cify Cuban, Mexican 2 X No specify:			14. Race - Ame White, etc. Specify: Bla	rican Indian, Black,
1215-0036 d be filed within 72 hours a fental Hygiene. narked other than "natura verent, the Medical Examin	Completed by	15. Decedent's Education (Spec Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of w	al Occupation (Give vorking life. DO NOT		lone	16b. Kind of Busines: ${ m N/A}$	/Industry
D 21215-0036 should be filed within 72 and Montal Hygiene. 7 is marked other than "astic event, the Medical	Be Con	17. Father's Name (First, Middle, Demonte A.				1	's Name (First Tisha		aiden Surname) Ord	
shoul ball	P	19a. Informant's Name/Relationsh LaTisha Ci	nip (Type, Print) cawford (Mothe		•	•		ne, 1	er, City or Town, Sta ${ m st}\ { m Flr}$ , Ba	ltimore MD
MOFE Pages 1 nent of F nnt: If i		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Sp		cremat	tory or other plac Memoria	al Park	6/1/2	012	20c. Location - City of Windsor N	ill, MD
Balti permit. Departu Importi		21. Signature of Funeral Service	onelle	S	2431	E. Oliver	Stree	t, Ba	Weatherfo	•
Physician Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		es of Head		e or dying, such as c	ardiac or resp	oracory arres	st, Shock, of Heart	Between Onset and Death
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cuted glassit transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
'60, ate be execut ohysician and	Medical	UNPENDED	d AMENDED	-					23d. Date of delive	any.
Box 6876 e death certificate the attending phy ed for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?  1  Yes 2  No 9  Unk	23c. If yes, outcome 1 Live birth 4 Pregnant at tim 9 Unknown	. f. d d.	Petal deat		c pregnancy		Month	Day Year
P.O. Es that the d	اھ	Part il. Other significant conditi	ons contributing to death b	ut not resultin	g in the underlyi	ng cause given in Pa	art I.			o the cause of death?
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed							24a. Was ar autops perform 1 ✔ Yes 2	y prior to ned? death?	
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Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Coul	atigation 28e. Place of Injur 28e. Place of Injur (Specify) Singl			pry, office building, e		or Town, Sta		Rural Route Number, City ore, MD
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Ph	nysician: To the best of my k miner:On the basis of examir and manner stated.	nowledge, de nation and/or	ath occurred at tinvestigation, in	the time, date and plant my opinion, death oc	ace, and due t	to the cause time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
F ¥ F 8	Me	29b. Signature and title of certifie			2	29c. License number O.C.M.E.			29d. Date signed (A May 28, 2012	onth, Day, Year)
2		30. Name and address of person Laron Locke MD. A	who completed cause of dea ssistant Medical Exam		) W. Baltimo	re Street, Baltir	nore, MD 2	21223		
S <sup>.</sup> Regis	tate trar	31. Date filed (Month, Day, Year)	012 £2. Registrar's	Signature	backer					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Q Ű Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign If Under 24 Hrs. Funeral 8. Date of Birth Days 1 🗆 M 2 🗆 F Months Hours Min Yrs Director Usual Residence of Decede 28a-f show 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director 1 ☑ Yes 2 ☐ No more 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married by permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee Home Na 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition ordiovasu Onset and Death Physician e Medical resulting in death) ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy page 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ၉ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? death. 2 🗆 No Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ည 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIAQAT ALI 821-N-Eutw S 31. Date filed (Month, Day, Year) MAY 3 1 2012 32. Registra's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 10e per fh g927 5-31-12 vt State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cheryl Ann Reid 11:45 M Medical 19 201 Mav 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1010 N.Washington Street #A Baltimore Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min. (Month, Day, Year) Months Days Hours Director 217-68-4461 1 □ M 2 🔀 F 55 01/01/1957 Maryland Usual Residence of Decedent th and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1010 N.Washington Street #A 21205 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify:Black 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hotel Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeping 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Earl Reid Betty Mae Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Importent: If item 27 is any injury or other trau Angela Reid/daughter 1010 N.Washington St.Baltimore MD.21205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/26/12 Landsdownes MD. Mt.Zion Cemetery 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on a spill line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and the for use es the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical or Attending Physician: The lew requires thet the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day P.O. signed by politions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to 26. Place of Death (Check only one) examiner? ျှ 1 Yes 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral d 27. Manner 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred tural Accident 5 Pending 1 ☐ Yes 2 ☐ No М Investigati 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of the Funeral Direct 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and litle of certifie of death (Item 23a) (Type State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:45PM GEORGE RIVERS 23 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Future care homewood Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 215-30-8551 1 □ M 2 🔀 F Director 76 Maryland 08/08/1935 Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits rector notified 28a-f 1 🏿 Yes 2 🗆 No Maryland Baltimore ō 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be 23a 21215 2612 Forest Park Avenue USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iten Black, White, etc. þ 1 Never Married 2 Married 1 ★ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Ith and Mental Hygiene.
27 is marked other than r traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel LongShoreman 9th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Thomas Handy Sandella Rivers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Gladys Armwood/Sister 2612 W.Forest Park Ave.Baltimore MD.21215 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō <u>+</u> cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 9 Department of Important: If any injury or once. Greenmount Cemetery 05/28/12 Baltimore MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd. Baltimore MD. 21215 21. Signature of Funeral Service Light see Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Failure to thrive disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** PVD Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate burial-transi Cause (Disease or injury that initiated events Dementia Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 the as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ jo in the past 12 months? Day Month Year Yes 2 No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 100 ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge; death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Shownest Kaus 73575 05 25 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bharaj. MD. 8814 waltham woods Rd, Parkville, MO - 21234

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARIE RIFFE Z6 - 2012 ARON 16.36 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 1+051TA HANFORD MEMORIAL HAURG de HARFORD Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕮 Months Days July 31,1962 Min. Hours Maryland 49 Director 220-84-5597 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10c. City Town or Location 10d. Inside City Limits Director Aberdeen Harford MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Baldwin Circle United States 21001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 ☐ Yes 2 A No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sephora Dist. Inventory Control 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Department of Health and Ment. Important: If item 27 is marked any injury or cat. Judith A. Schascheck John F. Ridgley 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 3404 North Point Road Dundalk, Maryland 21222 (Son) Jason Wenner Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 6/1/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail, re. List of the cause on each line. Approximate Interval Between Onset and Death CARDIOGENIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner +RTEL7 ULONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) the attending physician Physician/Medical ertificate be ion of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 

Yes 2 □ No 3 □ Probably 4 □ Unknown To the Frogram.

To the Funcral Director. After this certificate has been significate from the Funcral Director. After this certificate special of the Funcral director, page 2 should Completed 24b. Were autopsy findings available 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gartilying Number Practice of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. unity of 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21738 MAT. 29.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAVIE LE GRACE METRORIAL HOSPITAL HALFORD ALAN SWEATTLA 32. Registrar's Signature State Registrar

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

**Funeral** 

**Director** 

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items 23a

must be notified at

Director

by Funeral

Completed

Be

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Baltimore, Maryland 21215-0036 Page 1 and 2 should be . Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signatus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to item old to Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be as the IF FEMALE nse 23b. Was decedent pregnant page 2 should be detached for in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Diabet peen: has After this certificate 25. Was case referred to medical Be examiner? မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be filled in by the within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) D316 30. Name and add s of person who completed cause of death (Item 23a) (Type, Print) 7601 Osler Drive Towson. State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY CONSTANCE 2012 ROSS 8:22 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 614 SLIGO AVENUE #311 SILVER SPRING MONTGOMERY Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) Birthplace (State or Foreign Country) 579-42-4449 **Director** 80 JUNE 6, 1931 WASHINGTON, DC Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No MARYLAND MONTGOMERY SILVER SPRING 10e, Street and Number 10g. Citizen of What Country? Funeral 614 SLIGO AVENUE, APT. 20910 #311 UNITED STATES death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force 1 Never Married 2 Married 72 hours after ģ 1 ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. Specify: 3 Widowed 4 X Divorced Completed BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th 4 TEACHER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LEROY BANKETT PLEASANT SHORTER l and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DABORAH SMITH / COUSIN 614 SLIGO AVENUE #311, SILVER SPRING, MD 20910 injury or other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Durial 2 X Cremation 3 D Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 05-31-2012 RIVERDALE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. Daphney 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hypercension burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ξ Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an or Attending Physician: The law has page 2 autopsy performed? certificate 1 ☐ Yes 2 🗗 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 유 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined the Hospital Medical To the Hosp within 24 hou To the Fune completely fi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) an May 30, 2012 53235 who completed cause of death (Item 23a) (Type, Print) Darryl Hill 13635 Baltimore Ave Laurel, MD 20707

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's ignatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day 24 2012 Mary P. Ruiz May 5:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ellicott City Health and Rehab Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 10,1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 K F Months Hours 214-06-4000 97 Director Philippines Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 X No Director Maryland Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21029 11921 Meadow Vista Way U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 TYes 2 □ No Specify: Philippino þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be l 2 should be fi h and Mental H Maria Celeste Pacias Pascual Pacis ပ permit. Pages 1 and 2 sh. Department of Health and Important: If item 27 is m any injury or other traum. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11921 Meadow Vista Way Clarksville, MD 21029 Jose T.P. Ruiz Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1<sup>™</sup> Burial 2 □ Cremation 3 □ Removal from State Columbia Memorial Pk 6-1-2012 Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MOIOSO ms' Hader 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Atherosclerosis Cardiovascular Disease . Physician disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner death certificate be executed and resulting in death) Last physician a Due to (or as a consequence of): Box 68760. Physician/Medical attending ph IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 💆 No Month Day 5 Other (specify) Ö the detached 9 Unknown 9 Unknown þ ۵. signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 🙀 No the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ∏ Yes 2 🍱 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) Injury 1 Natural
2 Accident ours after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 24, 2012 D306641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi, MD 201 Back River Neck Rd #109 Essex, MD 21221

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death   Rep. No. 2   1   1   1   1   1   1   1   1   1		State of Maryland / Department of Health and Mental Hygiene									
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Modical Examiner    Sequentially list conditions consequence off:   Due to (or as a co	٦,	AND DESCRIPTION		shock, or heart failure. List only one cause on each line.			201,	Interval Between			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon J. Mc Cormack Mo 54/1 Old Frederick Rd - Scite 18 - Baltmore, Md. 2/229	8	cate b physi		d							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon J. Mc Cormack Mo 54/1 Old Frederick Rd - Scite 18 - Baltmore, Md. 2/229	8	certific	MM	23b Was decedent pregnant 23c. If yes, outcome of pregnancy			23d Date of	deliven			
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30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Sharon J. Mc Cormack Mo 54/1 Old Frederick Rd - Scite 18 Baltimore, Md. 21229	1	<b>⊢</b> ≶ <b>⊢</b> ō		I Shaw bo he lak MD							
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State 31. Date filed (Month, Day, Year) 32. Registry's Sign fure Registrar 31. Date filed (Month, Day, Year) 32. Registry's Sign fure		_0		5411 Old Frederick Rd - Suite	18 - Baltimore,	Md. 212	29	_			
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ie Ann Ritche		State of Marylar	iu / Departmer	e of Death	Mentari	Reg	Thomas	012 17172
	<u>F</u>	- For State Registrar  1. Decedent's Name (First, Middle,Last)	Certificat	0.0000		2. Date of Death		3. Time of Death
Physicia al Examir∷		1. Decedent's Name (First, Middle, Last)  Laurie A. Ritchey				Month May 19, 20		0250 hrs
al Examin	J.C.	4a. Facility Name (if not institution, give street and num	ber)	4b. City, Town, or	ocation of Dea	ath	4c. County of	
		715 Kidwell Street		Centreville			Queen Ar	
Funeral		J. Goolal Gooding Training	7. Age (In yrs. last birthd	lay) If Under 1 Year Months Days		Irs. 8. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or Foreign WASNIng ton
Director		217-64-8836 <sub>1 M 2</sub> F	55	Yrs. Months Days		0-24-1	950	DrytrictofColumb
	ŀ	Usual Residence of Decedent	10c. City, Town or	Location				10d. Inside City Limits
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and [show	اق	Maryland Queen Anne's	Centre	10f. Zip Code		10	g. Citizen of Wha	at Country?
Maryl 288-1	Director	10e. Street and Number 715 Little Kidwell Aven	ue	21617			U.S.A.	
1, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland calth and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at once.				13 Was Decedent of His	panic Origin?	Specify Yes or No-	14. Race -	American Indian, Black,
th wit	Funeral	1 Never Married 2 Married Armed Fo	rces?	If Yes, specify Cubar	, Mexican, Pue	erto Rican, etc.)	White,	
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5-00 iled wit Hygien other		17. Father's Name (First, Middle, Last) Raymond Sansbury				ey M. Brya		
Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours af nent of Health and Mental Flygiene. Health and Mental Flygiene. The 27 is marked other than "natural or other traumatic event, the Medical Examin	Be C	19a. Informant's Name/Relationship (Type, Print )	19b.	. Mailing Address (Stree	et and Number	or Rural Route Num	ber, City or Town	n, State, Zip Code)
Should and Maric c	Ç	Kenneth G. Ritchey	1	.453 Hidden	Meacki	n Lane.Sa	lisbury	Maryland 21801 City or Town, State
and 2 calth :		20a Method of Disposition	20b. Place of	Disposition (Name of ce	metery,	Date 26 12	20c. Location -	City or Town, State
Ore ges 1 a t of H ther t		1 X Burial 2 Cremation 3 Removal fr	om State Yello	w Creek		-26-12	нореже.	ll,Pennsylvania
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Reform	med Cemeter 22. Name and dire		Marzullo 1	Funeral	Chapel, P.A.
Bal permi Depar Impo injur		michael P. marentlo		6009 Harfo	rd Roa	l. Baltimo	ore Mary	land 21214
Physician		23a. Part I. Enter the disease, tomplications that of failure. List only one cause on each line.	aused the death. Do not	t enter the mode of dying	, such as cardi	ac or respiratory arre	est, shock, or hea	art Approximate Interval Between Onset and Death
Medical		failure. List only one cause of lead fine.  Compliance (Final disease a. Compliance)	cations of	Lung Cancer				Death
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	L	Sequentially list conditions,  Due to (or as in the leading to immediate)	a consequence of):					
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ਜ਼ਾਲ ਦੇ	.≃		outcome of pregnancy	ше, в лел 1—1	- 12 5		23d. Date of	delivery
Records, P.O. Box 68760,  The law requires that the death certificate be from the law persisted by the attending physici name 2 should be detached for use as the burit	Physician/Med	IF FEMALE: 23c. If yes, 23b. Was decedent pregnant in the		Fetal death 3	Ectopic p	egnancy	Month	Day Year
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BOY e death the att	12	1 Yes 2 No 9 Unknown 9 Unkr		o in the underlying cause	given in Part	. 23e. Did t	obacco use cont	ribute to the cause of death?
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D, D ires tl 1 signe d be d	2					24a. Was		Were autopsy findings available
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Division of Vital Records, talor Attending Physician: The law requirers after death.  In a Director: After this certificate has been sind in his the finered mase 2 should the control of the physician control of the physician page 2 should the control of the con	8				Other4	Nursing Home 5	Residence 6	✓ Other: Scene
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Spital hours neral			t -f linoudadaa da	eath occurred at the time	date and plac	e, and due to the cau	use(s) and mann	er as stated.
Divisior To the Hospital or Attend within 24 hours after death to the Funeral Director	biene	Check only one) 2 Medical Examiner: On the basic	s of examination and/or	investigation, in my opin	ion, death occ	irred at the time, date	e and place, and	
To the Vithin To the	Com	(Check only one) 2 Medical Examiner: On the basi and manne 29b, Signature and title of certifier	r stated.		ense number			ned (Month, Day, Year)
	1	10 ch. h. 10		0.	C.M.E.	hlat:	May 19, 2	2012
4		30. Name and address of person who completed ca	ause of death (Item 23a)	)		<u> </u>		
Q		Laron Locke MD. Assistant Medi	cal Examiner 90	0 W. Baltimore Str	eet, Baltim	ore, MD 21223		
	Sta	2 to Start Marth, Day Yeard 2	Registrar's Signature					
		r Date med modulos burnedal/						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7829 Denton Avenue Sparrows Point Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Min 5 Director 185-22-0759 04/06/1927 Pennsylvania 10a. State 10b County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD Baltimore Sparrows Point o 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 7829 Denton Avenue U.S.A. 21219 "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Completed Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Registered Nurse Healthcare of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Andrew Stephen Sitzi Marv Josephine Sebastian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Speece / Son 7829 Denton\_Avenue, Sparrows Point, MD 21219 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of | Department of Important: If i any injury or o cemetery, crematory or other place 1 
Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 05/24/2012 Anatomy Gifts Registry Hanover, Maryland Signature of Funeral Pervice Licenses 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for I in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed 2 No death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 100 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: Jo he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: (Check tyle basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Sertifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the D0011312

State Registrar 30. Name and add

31. Date filed (M

OIN

Year

1665 MERRITT BLUD

who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Thomas H. Stinchcomb Medical May 26 2012 10:53 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17 Queen Anne Rd Glen Burnie Anne Arundel Social Security Numbe If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min 220-16-7928 Director **X** ★ M 2 □ F 86 Usual Residence of Decede Nov 3, 1925 MD or 28a-f shov with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director be notified MD 1 ☐ Yes 2XX No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a must b 17 Queen Anne Rd. 21060 USA death \ 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or ite the Medical Examiner Armed Forces 01. Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify. 3 Widowed 4 XX Divorced Specify: Completed Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Rigger Baltimore Rigging Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked o traumatic eve ပ Stinchcomb Catherine unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kelly Stinchcomb 17 Queen Anne Rd., Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ott once. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Glen Haven Cemetery May 30, 2012 Glen Burnie, MD 21. Signa are of Funeral Service Licensee 22 Name and Address of Facility Fink Funeral Home, P.A. Oregory (Kink M01148 426 Crain Hwy S., Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ m 0 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE for use yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performe Hospital or Attending Physician: The Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prantitionar To the best of my knowledge. Just the counted at the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

NAY 3 1 2012

32. Registrar's Sign

32. registrar's Signature

4105 Old Court Rd., Randallastown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** RIA 2012 45 A M MAY 22 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITA N/A BALTIMOR E HARBOR If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 76 Yrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex West Virginia **Funeral** Days Hours Months 1 □ M 2 🔀 F 212 34 4227 03/09/1936 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.

If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Anne Arundel Baltimore Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21225 107 Doris Avenue Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 反 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Cook Coast Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wayne Thompson Mary Akers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Debbie Kemmer / Daughter 107 Doris Avenue Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Olen Haven Mem. Park | 05/25/2012 | Important: I any injury o Glen Burnie, Maryland Department 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Manuscoup 4001 Ritchie Highway Baltimore, Maryland 21225 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Par A Inter the disease, or coving shock, or heart failure. List only Immediate Cause (Final ESPIRATOR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** organisms list sonditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed STA and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No the 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔁 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s certificate has **3**♥ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 21X No **1** Inpatient ျှ this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After t Certification: After t Injury (Month, Day Year, 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Records, Division or Vital

State

3001 SOUTH HANDVER STREET BALTIMORE, MD 21225 MASRI Dr. HASSAN 31. Date filed (Month, Day, Year) MAY 3 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MY

Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Storen MAGIE AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlestown Catonsville Nursing Home Baltimore Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 217 34 5420 Director 1 M 2 X F 93 England [ ] 10/30/1918 Usual Residence of Decedent 28a-f show 10a, State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Delaware Sussex Seaford 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Marathon Drive 19973 U.S.A. and 2 should be filed within 72 hours after death Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Yes 2 X No Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 x Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager BGE Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Cooper Margaret Arbuckle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Storey / Son 7 Marathon Drive Deaford, Delaware 19973 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Durial 2 X Cremation 3 Removal from State 05/23/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory f F neral Service 21. Signat 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death Pancheatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or Injury that initiated events signed by the attending physician and abe detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 2 No 3 Probably 4 Unknown 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy
performed?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) R144682 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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Ink Unk	State of M 1- For State Registrar	aryland / Departmen <i>Certificate</i>	t of Health and Mental I e of Death	Hygiene Reg.	201	2 1717
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	SHIRD, JA	2.	2. Date of Death Month D May 24, 201	ay Year	3. Time of Death 1844 hrs
	4a. Facility Name (if not institution, give street 4624 York Road	and number)	4b. City, Town, or Location of Dea Baltimore	ath	4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 17-39-3002 1⊠M 2	7. Age (In yrs. last birthda		Irs. 8. Date of Birth()	/ - Foreign	place (State or ntry) MD
	Usual Residence of Decedent			10 17 17		10d. Inside City Limits
d aow any	10a, State 10b, County	10c. City, Town or I				1 Yes 2 No
Aarylan 28a-f sl 1 at onc	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Count	ry?
th the N 23s or notified	6021 ARIZONA 1		2120 6 3. Was Decedent of Hispanic Origin? (	Specify Yes or No-	USA 14. Race - Americ	an Indian, Black
r death with the Maryland or items 23s or 28s-f she r must be notified at once Funeral Director	1 Never Married 2 Married 1	rmed Forces? Yes 2 X No	If Yes, specify Cuban, Mexican, Puel		White, etc.  Specify: BL	
urs afte tural", uniner	3 Widowed 4 Divorced If Yes, or Dat  15. Decedent's Education (Specify only high	es: est grade completed) 16a. Dec	edent's Usual Dccupation (Give kind o		6b. Kind of Business/In	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f ahe or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	ng most of working life. DO NOT use r $000$	etired)	RESTAUR	ANT
ID 21215-0036 should be filed within 7 and Mental Hygene. 7 is marked other than natic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last)  JAMES SHIRO	Se	ANIT		EY	
D 2121(should be fill man Mental I is marked attic event,	19a. Informant's Name/Relationship (Type, P	rint ) 19b. N	lailing Address (Street and Number of	or Rural Route Numbe	er, City or Town, State,	Zip Code)
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	20a. Method of Disposition	20b. Place of D	221 ARIZONA AV	Date 2	20c. Location - City or 1	own, State
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum	1 Burial 2 Cremation 3 Re 4 Donation 5 Other Specify:	moval from State	isposition (Name of cemetery, or other place)	11/2012	DOHIMO	KE, MD
Balti permit. Departu Importu injury o	21. Sign that of Furnia Servio Licensee	1553	22. Name and Address of Facility 4905 YORK ROP	AVIGNIV 6	RECIVERO	NERTIC
Physician	23a. Part I. Enter the disease, or complication failure. List only one cause on each line	s that caused the death. Do not e	nter the mode of dying, such as cardia	c or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Medical Examiner	Immediate Cause (Final disease a Multi	ple Gunshot Wounds (or as a consequence of):				Death
5	Sequentially list conditions, b. b. b. Due to	(or as a consequence of):			-	
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	(or as a consequence of):				
cuted und transit	events resulting in death) Last Due to	(0, 45 4 55) 154 25)				
60, e be executed ysician and burial - transit		NDED			23d. Date of delivery	
5876 rrtificate fing phy as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Live birth 2	Fetal death 3 Ectopic pre	gnancy		ay Year
). Box 6876( the death certificate by the attending physoched for use as the brysician/Me	1 Yes 2 No 9 Unknown 9	Pregnant at time of death 5	Other (Specify)			
tal Records, P.O. B cian: The law requires that the d certificate has been signed by the ector, page 2 should be detached Be Completed by Phy.	Part II. Other significant conditions contr	buting to death but not resulting in	the underlying cause given in Part I.		acco use contribute to t	
Records,  The law require ficate has been si page 2 should b. Completed				24a, Was an autopsy	prior to co	opsy findings available ompletion of cause of
Reco The law cate has page 2 s				perform 1 <b>✓</b> Yes 2		s 2 No
ital Be C	25. Was case referred to medical examiner? Hospita	II: 1 Inpatient 2 ER/Outp	26.Place of Death (Che		esidence 6 🗸 Other:	Scene
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be deach ledical Certification: To Be Completed by P	1 Natural 5 Pending	Ba. Date of Injury 28b. Time (Month, Day, Year) FOUND:	ne of Injury 28c. Injury at Work? D: 1 Yes 2 ✓ No	28d. Describe hor Subject shot		
Division o spital or Attending nours after death. neral Director: Afte filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be	May 24, 2012 1830 h 8e. Place of Injury - At home, farm	, street, factory, office building, etc.	28f. Location (Stroor Town, State	eet and Number or Ruite)	al Route Number, City
Diversity ospital of hours a nucral I y filled	4 Homicide determined	Specify) Alley	occurred at the time, date and place, a	4624 York Road	d, Baltimore, MD	nd
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	one) 2 Medical Examiner: On the	o the best of my knowledge, death he basis of examination and/or inve manner stated.	estigation, in my opinion, death occurre	ed at the time, date an	nd place, and due to the	e cause(s)
F S F S B	29b. Signature to little f certifler		29c. License number O.C.M.E.		29d. Date signed <i>(Mor</i> May 25, 2012	nth, Day,Year)
OCME	30. Name and address of person who comple		000 W D	Minner 147 040	100	
State		0.00	900 W. Baltimore Street, Ba	itimore, MD 212	23	
Registra	ייוותי דו שוע שו	Deserve B. 1	barker !			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2012 **EVELYN** SCOTT 8:55 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PATUXENT RIVER HEALTH & REHAB CENTER LAUREL PRINCE GEORGE'S Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Days Country **Director** 267-36-5392 1 □ M 2 🗓 F 95 APRIL 17,1917 SOUTH CAROLINA Usual Residence of Decedent 10b. County 10a. State the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MARYLAND PRINCE GEORGE'S LARGO 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code must be r 10g. Citizen of What Country? Funeral UNITED 9610 TEAKWOOD DRIVE 20774 STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ō Examir þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify: BLACK the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SUPERVISOR 12 TH PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic even မ ELZEY WILLIAMS EMMIE **JENNINGS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ent of Health a tr: If item 27 is y or other tra ALEXANDER PRIDE / SON 9610 TEAKWOOD DRIVE, LARGO, MARYLAND 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Page 1 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Department o Important: If any injury or RIVERDALE CREMATORY 05/27/2012 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. Naphney 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Opset and Death
5 YEARS Ph sician ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a sorreequaries of): cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, SENTLE DEMENTIA 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Hospital or Attending X Natural 5 Pending injury death. To the Hospital or Attendi within 24 hours after death To the Funeral Director; A Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24721

State Registrar

DHMH 17 Rev 06-2011

14333 LAUREL BOWIE ROAD, STE.208, LAUREL, MARYLAND 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SYED A SADIQ, M.D.

2012

31. Date filed (Month, Day, Year)

MAY 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 24, 2012 DELORIS SAUNDERS 9:20 Μ.  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOLY CROSS HOSPITAL STLVER SPRING MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Min (Month, Day, Year) Director 266-48-3344 1 □ M 2 🕅 F 77 OCT. 15, 1934 FLORIDA Usual Residence of Deced 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? or items 23a 531 RANDOLPH ROAD 20904 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 ☐ Yes 2X No Specify "natural", Specify: 3 Widowed 4 Divorced Completed BLACK Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ **EDUCATOR** GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed hand Mental H 7 is marked of မှ WILLIAM R. MIII.DROW GRACE BRADFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other fra... WILLIAM A. SAUNDERS / SON 19303 CLUB HOUSE ROAD #104, MONTGOMERY VILLAGE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State GATE OF HEAVEN CEME. D6/01/2012 SILVER SPRING, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee - N Naphney ornalus 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani ADVANCED AGGRESSIVE MULTIPLE MYELOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ASPIRATION PNEUMONIA intially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) death certificate be executed SMALL BOWEL OBSTRUCTION sician and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last ysician Physician/Medical SEIZURES Box 68760 IF FEMALE Ise 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy P Mo*n*th Day Year 5 Other (specify) Pregnant at time of death ed by the a g Unknown q Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Jas page 2 Hospital or Attending Physician: The 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\boxtimes$  Other (Specify) HOSPICE ျပ 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this of filled in by the funeral di this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year, D73240 MAY 24, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANISHA KUMAR, M.D. 1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND 20910 32. Registra s Signat State

DHMH 17 Rev 06-2011

Registrar

12-04058 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Ettice Sherin Smith State of Maryland / Department of Health and Mental Hygiene									
Ettice Sheriii Shi			te of Death		2012 1718				
Physicia Medical Examii	ın/	1. Decedent's Name (First, Middle,Last)  Ettice Sherin	Smith	2. Date of Death	3. Time of Death				
		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore	h	4c. County of Death				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24Hrs Months Days Hours Mir	_	(MM/DD/YYYY) 9. Birthplace (State or Foreign NOTTh Country) Carolina				
<u>k</u>		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	rlocation		10d. Inside City Limits				
land f show any once.		MD	Baltimore		1 X Yes 2 No				
the Mary 3a or 28a	Öire	1239 Woodbourne Avenue	10f. Zip Code 21239		g. Citizen of What Country? USA				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify.Black				
rs after ural", miner	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. D	1 Yes 2 No specify: ecedent's Usual Occupation (Give kind of	work done	Specify: Specify: 16b. Kind of Business/Industry				
36 iin 72 hou ihan "nat dical Exe	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use ret Health Care Worker		Private				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)		e (First, Middle, M					
121 Id be fi Aental narked event,	BB	Ronald D. Smith  19a. Informant's Name/Relationship (Type, Print)  19b.	Mailing Address (Street and Number or	S E. Hil					
MD 2 d 2 shou th and h n 27 is n	٩		1239 Woodbourne Ave	enue, Bal	timore MD 21239				
or Heal of Heal		1 Rurial 2 X Cremation 3 Removal from State cremator	Disposition (Name of cemetery, ry or other place)	Date 31/2012	20c. Location - City or Town, State				
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	-	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	t Cremation 5/ 22. Name and Address of FacilityPhi		Hanover, MD Weatherford FS.PA				
Ba Pem Depu		While My enelland	2431 E. Oliver St	reet, Ba	ltimore MD 21213				
Physician /Medical		23a. Part I. Erfer the disease, or complications that caused the death. Do not failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Sharp Force Injuries	enter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart Approximate Interval Between Onset and Death				
Examiner		or condition resulting in death)  Due to (or as a consequence of):							
	Iner	Sequentially list conditions, if any, leading to immediate  cause. Enter Underlying Cause							
xecuted n and - transit	cal Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.							
\		UNPENDED AMENDED							
Box 68760, - death certificate be except at a sending physician ed for use as the burial-	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death	Fetal death 3 Ectopic pregn	nancy	23d. Date of delivery  Month Day Year				
Box e death the atter	hysic	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)						
P.O.	Ď	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	promp	pacco use contribute to the cause of death?  2 No 3 Probably 4 Unknown				
tal Records, cian: The law requirection to certificate has been sector, page 2 should	Completed			24a. Was a autops perform	y prior to completion of cause of ned? death?				
Re n: The tificate or, pag		25. Was case referred to medical	26. Place of Death (Check	1 ✓ Yes 2 conly one)	No 1 Yes 2 No				
Vita hysicia this cer	ro Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Ou			Residence 6 Other:				
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director.	tion: T	1 Natural 5 Pending May 28, 2012 2200	ime of Injury  2Bc. Injury at Work?  1 Yes 2 No	28d. Describe h Subject assa	ow injury occurred rulted				
Division pital or Attend tours after death. coral Director: filled in by the I	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Townhouse / Ro	rm, street, factory, office building, etc.	or Town, St	treet and Number or Rural Route Number, City ate) urne Avenue, Baltimore, MD				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dear one)  Medical Examiner: On the basis of examination and/or in							
To with	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)				
2		Theolen My King Thy Me	O.C.M.E. 00	ME	May 29, 2012				
6			ner 900 W. Baltimore Street, I	Baltimore, MD	21223				
S Regis	tate trar	31. Date filed (Month, Day, Year)  AAY 3 1 2012  32. Registrar's Signature	back						

DHMH 17 Rev 1/2001

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death STEWARI Physician/ Manthal Year 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 216-03-9811 1 🛛 M 2 🗆 F 95 Usual Residence of Decedent Aug. 14, 1916 MD or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 🙀 No Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 8911 Reisterstown Road 21208 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify. Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles I. Stewart, Sr. Pearl Uhler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 Charles I. Stewart, III Son 400 Symphony Circle, Unit 61C, Cockeysville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1  $\fill X$  Burial 2  $\fill C$  Cremation 3  $\fill B$  Removal from State 4  $\fill D$  Donation 5  $\fill D$  Other (Specify) 4 ☐ Donation 2.1. Signature of Funeral Service Licensee M Druid Ridge Cemetery 6/01/2012 Pikesville, MD 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ENAL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and defeached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by is certificate has been sig director, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an the Hospital or Attending Physician: The law prior to completion of cause of death?

1 Yes 2 No autopsy this certificate 1 Yes 2 b Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Man of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 8595 30 Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

DHMH 17 Rev 06-2011

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies, Are Legible, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8 Year Physician/ Walter Paul Saylor Month  $A^{\mathsf{M}}$ 05-25-201 8:48 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death **Examiner** Arbutus 5892 Selford Rd. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 PA **Funeral** Juny D2/5/9ar) 1934 Days 205-26-2593 1 XM 2 AF 05/25/201 Director Usual Residence of Decedent Fshow City Town or Location
Hilton Head Island
Arbutus 10d. Inside City Limits 10a State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore MD 10f. Zio Code 29928 10g. Citizen of What Country? 239 Beach City Rd. Apt.#3235
5892 Selford Rd. Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 White Saylor 1 ☐ Yes 2 K No Specify Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
jife. DO NOT use retired)
COORDINATER 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Set on dary (0-12) College (1-4 or 5+) Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma G. Harr Mental ဂ္ Cloyd L. Saylor 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number of Rural Route Number, City or Town, State Zip Code) 35243 Turner Dr. Sterling Heights, MI 48312 Roger Saylor, son f Health item 27 20a. Method of Disposition
1 □ Burial 2 █ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 Atlantic Crematory 05-26-2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. A Arbutus, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) UI SEGS andiouascular Physician/ Ar tellosclero Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to fur as a consequence on Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Dementio autopsy performed? 1 Yes 2 No this certificate Hospital or Attending Physician: **Division of Vital** the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Son's examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA House 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural injury 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 U Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) are and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number completed cause of death (Item 23a) (Type, Print) MD (0) winh 31. Date filed (Month, Day, Year, 32. Registrar's Signat State MAY 3 1 2012 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / D	epartment of Health and	Mental Hygier	ne
			State Registrar		Certificate of Death	Reg.	No. 2012 1716
	Physicia	n/	1. Decedent's Name (First, Middle, La	·		Date of Death     Month	Day Year 3. Time of Death
Jane.	Medic	al		TOLES		05	28 2012 0217A
	Examin	er	4a. Facility Name (if not institution, giv	a street and number)	4b. City, Town, or Location of Deat	th	4c. County of Death
	Funeral			$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	day) If Under 1 Year   If Under 24 Hrs	8. Date of Birth	Birthplace (State or Foreign
	Director		218-62-2472	I M 2 VE	rs. Months Days Hours Min.		53 Maryland
	- MO		Usual Residence of Decedent				
	ryland I-f show ied at	cto	10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	r 28a notif	Dire	10e, Street and Number	A J	10f. Zip Code		
	vith th	rai	817 Adiata	1. 1. 1. 1. L#	21217	10g.	Citizen of What Country?
	eath v	Funeral Director	11. Marital Status	12. Was Decedent Ever if U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
98	fter d , or i	by	1 Never Married 2 Married	Armed Forces?  1  Yes 2  Ao If Yes, Give	If Yes, specify Cuban, Mexican, Puerl  1 Yes 2 No Specify:	to Rican, etc.)	Black, White, etc.
70 L E S	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at	Completed	3 ☐ Widowed 4 ☑ Divorced	Year or Dates.			Specify: Black
7 5	72 hc n "na Aedic	nple	15. Decedent's (Specify only highest g	rade completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use (etired)	rking 16b	b. Kind of Business Industry
212	ed within Hygiene. other tha ent, the I		Elementary/Seconday (0-12)	College (1-4 or 5+)	Conk		College
	를 불 를 등		17. Father's Name (First, Middle, Last)	0 1	18. Mother's Na	me (First, Middle, Maid	en S <i>umam</i> e)
₹ <u>a</u>	D P 2 0	욘	James:	T. Parker	Luc	Y T.	Burch
554 Maryland	sh as is		19a. Informant's Name/Relationship (		Mailing Address (Street and Number or Ru	1 1 1 -	
	1 and 2 of Health item 27 other tr		20a. Method of Disposition	4. 10/es 10	007 Bruce Ct.		uto., MO 2121
A m or			1 Burial 2 Cremation 3	Removal from State Cemetery	Disposition (Name of , crematory or other place)	1.	Location - City or Town, State
$VAN^{\epsilon}$	permit, Page Department Important: I any injury or once.		4 ☐ Donation 5 ☐ Other (Spec		lawn Cemetery 6-3		Soodlawn, MD
B	permit, Departr Importa any inju		1 taulle >	Hurses t. The	Joseph Li Rus	3 Funeral	Home, P. A.
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	ipplications that caused the death. Do no	et enter the mode of dying, such as cardiac		Approximate
	Ph, sician/	, ,	Immediate Cause (Final disease or condition	The cause of each line.	L:10 500505		Interval Between Onset and Death
	Medical Examiner		resulting in death)	a.  Due to (or as a consequence of	):		
	LXdiffiller	-e	Sequentially list conditions,	b. Chronic Le	g U/cer		
	ed sit	Examin	cause. Enter Underlying Cause (Disease or iinjury	Drive to for as a consequence of			
	executed an and rial-transi		that initiated events resulting in death) Last	c. Due to (or as a consequence of	):		
09	e be e ysicia e buri	edical		d			
876	certificate be nding physicia use as the bur	Med	IF FEMALE:				
Box 687	th cert	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3  Ectopic pregnancy		23d. Date of delivery
	e death of the atter hed for u	Physician/M	1 Yes 2 No	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month Day Year
Ö.	at the	F.		contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
S, F	requires that the been signed by the should be detach	d by					2 No 3 Probably 4 Onknow
ord	v requ	Completed				24a. Was an	24b. Were autopsy findings available
ec €	The law cate has t page 2 s	mo o				autopsy performed	
<u>a</u>	ian: T	Bec	25. Was case referred to medical examiner?		26. Place of Death (Che	1  Yes 2 ck only one)	No 1 Yes 2 No
Ş	hysic his ce I direc	၉	1 ☐ Yes 2 ☑ No	Hospital:	patient 3 DOA Other: 4 Nursing I	Home 5 Residence	6 Other (Specify)
o c	ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury 28b. Tii (Month, Day, Year) inj	ury work?	28d. Describe how in	jury occurred
jo	ttend death stor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not l	20	M 1 Yes 2 No		
Division of Vital Records, P.O	after Direc	Ce	4 Homicide determined	28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical	29a. Certifier 1 Deertifying Phy	/sician: To the best of my knowledge, d	eath occured at the time, date and place,	and due to the cause(s)	and manner as stated.
	he Ho in 24 i he Fu pletec	Medical	(Check 2   ☐ Medical Exam	iner: On the basis of examination and/or	investigation, in my opinion, death occurred dge, death occurred at the time, date and pl	at the time date and nla	ace, and due to the cause(s) and manner stat
	To the To the Control		29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
1			* Hungh U	un J	189736	M	ay 28, 2012,
	BV		Name and address of person who	completed cause of death (Item 23a) (Ty		/ //	821 Linden Ave
	Stat		31 pagilled (Mentin Ray Year)	32. Redistrar's Stanature	Maryland Grener	201 1-105/	ital Balto, Modial
	Registra		MAI 3 1 2012 Per	un f. parks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wanda Jeanne Jones Trafton PM 1:10 Medical Ma-23 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 27197 1951 Director 214-58-8281 1 □ M 2 🕅 F 60 Maryland 28a-f show items 23a or 28a-f shorer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Windsor Mill 1 Yes 2 No 10e Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 3630 Eitemiller Road 21244 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner 5 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 K Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Marc Train izatton, wanda should be filed within and Mental Hygieners is marked other the Transporter years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oscar Connors Jones Mary Segar injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Darlene Trafton/daughter 4130 Hyden Court Baltimore, MD. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 5/29/12 Baltimore, Maryland Greenmount Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licente 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final inset and Death Physician/ sepsis | Enterococcal Bacterenia disease or condition 16 days Medical resulting in death) Due to (or as a consequence of) Examiner 3days. severe anasarca i hypotension Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ģ in the past 12 months? Pregnant at time of death Month Day Year be detached the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ESPD, ESLD, DILATED CARDIOMYOPATHY, HTN Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes \( 2 \sum \) No 24a. Was an has page 2 autopsy performed Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ပု 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) HOSP (E 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: After 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be within 24 hours after deal To the Funeral Director 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled n by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) RES 000 May 23,2012 MD

State Registrar SINCI HOSPITAL OF BALTIMORE, 2401 W. BRIVETERS AVE, BALTIMORE, MD

21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aileen Pan IMD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ 2012 Medical Location of Death Examiner 4c. County of Death Baltimore brook Mal If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 9. Birthplace (State or Foreign **Funeral** a 1 M 2 WF Country) **Director** 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director ms 23a or 28a-f s must be notified timore 1 Yes 2 No 10g. Citizen of What Country? brook USA ral", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital\_Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-6036 1 Yes 2 No Specify: Black "natural" 3 Widowed 4 Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DG NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ary/Secoliday (0-12) College (1-4 or 5+) Mental Hygiene. 24 Be 18. Mothar's Name (First, Middle, ၉ Informant's Name/Relationship (Type, Print) or other 20b. Place of Disposition (Name of competery, symatory or other place) 20a. Method of Disposition Date permit. Page 1 Department of Important: If it any injury or o ō ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Nationa 23a. Part 1. Enter tha isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Seiture disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** eizure Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) cerebral ed by the attending physician and detached for use as the burial-trar that initiated events Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Other (specify) g Unknown g Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by t completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 
Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \(\sum \) Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 28 30. Name and address a person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 3 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 7:05 a<sup>M</sup> 2012 May 28, Townsend G. Evelyn Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Futurecare Cherrywood Reisterstown g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Country Months 75 Director 218-34-1768 1 🗌 M 2 🕱 F July 30, 1936 Maryland Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No MD Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21136 U.S.A. 103 Northway Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give "natural", White Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Supervisor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Bertha L. Pickett Grothe George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 241 Highmeadow Road Reisterstown, MD Gae B. Ray Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 6/1/12 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 11824 Reisterstown Road Signature of Funeral Service Licenses Mess ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ercloras disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exec Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use es, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Year in the past 12 months?

1 Yes 2 No Month Day Other (specify) Pregnant at time of death been signed by the a should be detached f 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 1 🗌 Yes 2 🗌 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🔀 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After t iniury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Raymond

31. Date filed (Month, Day, Year)

Mille

MAY 3 1 2012

DHMH 17 Rev 06-2011

Registrar

awings

mile

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1525

2. Registrar's Signature

29c. License number

Mills

047683

MD

21117

5/29

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 10e, per FH, G927, 571, 2012, WS per FH, G927, W Reg. No. 20 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2:40 PM 26 05 2012 Turner Otis D. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square Hospital BA Himore ROSeDAle If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Mar. 25, 1952 Director 212-56-2686 Usual Residence of Decedent 60 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County nt of Health and Mental Hyglene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'm Medical Exercises must be notified at X Yes 2 □ No Director Baltimore Nottingham 10f. Zip Code MD 10g. Citizen of What Country? 10e. Street and Number Way 21236 USA 37 Eagles Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: δ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12th Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ollie Horton Willie Otis Turner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar 37 Eagles Way, Nottingham, MD Danielle Stokes (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Mem.Pk. June 1,2012 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 21. Signature of Fundral Convictor Licenses 21213 1412 E. Preston St. Balto, Md. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. stroke Immediate Cause (Final INKNOWN Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Poglycemi Examiner UNKNOWN Sequentially list conditions, if any, leading to humodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 XNo 9 Unknown 9 Unknown Part I<mark>]. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an autopsy performed? Yes 2 No 1 ☐Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 MNo 1 Natient 2 I ER/Outpatient 3 I DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Artifier MAY, 26, 2012 D69198 Ko Hutil MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 9000 Franklin Square DrivE BAltimore, MD 21237

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 3 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 345 PM ZOIZ arenc Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City. Town, or Location of Death Examiner Baltimore 1ti more 8. Date of Birth (Month, Day, Year) 5–14–1934 7. Age (In yrs. last birthday) If Under 1 Year If Under Birthplace (State or Foreign Country) **Funeral** Days 228-38-8533 1 X M 2 □ F Months Hours Director 78 VIRGINIA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other transitions. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD. N/ABALTIMORE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2802 PINEWOOD RD 21214 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð ☐ Yes 1 ☐ Yes 2 ▼No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) APARTMENT COMPLEX MAINTENANCE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 GEORGE TRAYNHAM MARY VIRGINIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VANESSA PURNELL (DAUGHTER) 2703 FLEETWOOD AVE. BALTIMORE, MARYLAND 21214 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 4 Donation 5 Other (Specify) KING MEMORIAL PARK 6-1-2012 BALTIMORE, MARYLAND 21. Signature of Funcial Sen HIBNEY 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. JONATHAN D. MARYLAND 21217 1721-27 N. MONROE ST. BALTIMORE . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 Priysician/ heimer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death 4 Pregnant the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of completed filled in by the funeral ë 28d. Describe how injury occurred 28c. Injury at work?
1 Yes 2 No iniury 5 Pending Natural Certificat 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who complete 2122

State Registrar Bi AmBRose Vasold

			Please	Type or Prin						-		gible.	
			For State	State of Ma	ryland					Mental Hy	_	012	17196
			Registrar  1. Decedent's Name (First, Middle, Las	n+1		Cer	tificate or	Deati	n	T	Reg. No. 2	012	11130
	Physicia Media			Ambrose	Edwa	ard V	asold			2. Date of De Month	Day	Year 2012	3. Time of Death 10 30 A M
	Examir	ner	4a. Facility Name (if not institution, give		÷ /		4b. City, Town						
			FRANKLIN SQUA		(In yrs. las	t hirthday)	If Under 1 Ye		dale der 24 Hrs.	8. Date of Bir		- 1	place (State or Foreign
	Funeral Director	П	212 12 221	¥ MaDE	. ,	Yrs.	Months Day			(Month, Da	y, Year)	Coun	ntry)
	3		Usual Residence of Decedent	A						April	30,1924		yland
	yland f shc ed at	to!	10a. State 10b. County		10c. City,	Town or Loc	eation					1	10d. Inside City Limits
	Mar 28a- notifie	jre	MD Balti	more			Last 21 0 1		F	Rosedale			1 Yes 2 X No
	ith the	a	10e. Street and Number 1516 Chapel Hil	1 Drivo			10f. Zip Code	237			10g. Citizen o		•
	ath w	by Funeral Director	13.10 Shaper Inti	12. Was Decedent Ev	er in U.S.	13. V			Origin? (Sp	ecify Yes or No-	United	ace - Americ	
ယ	or ite	Jy F	1 Never Married 2 Married	Armed Forces?	lo	l II	Yes, specify Cu	ıban, Mexi	ican, Puerto			lack, White,	
03	ırs aft ıral", I Exa	ed	3 🖾 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.	WII	1	Yes 2X	No Spec	cify:		Speci	fy:	White
21215-0036	2 hou " <b>nat</b> a	Completed	15. Decedent's E (Specify only highest gr			(Give F	lent's Usual Occ kind of work dor	e during n	nost of work	king	16b. Kind of		
121	thin 7 ane. <b>than</b> he M	E O	Elementary/Secondary (0-12)	College (1-4 or 5+	.)		O NOT use retire	,				imore tric C	
d 2	ed wi Hygie other ent, t	l do l	12 Years  17. Father's Name (First, Middle, Last)			Mete	r Inspe		other's Nam	ne (First, Middle,			
lan	be fillental	욘	George Charles	Vasold					Ма	rv Paul	ine Mil	llor	
Maryland	should and N is ma		19a. Informant's Name/Relationship (7	ype, Print)	-0	19b. Mailin	g Address (Stre	et and Nui		al Route Numbe			Code)
	nd 2 sealth n 27		Michele M. Vaso	ld (Daughte	≘r)	1516	Chape1	Hi11	Driv	e Rose	dale, N	D 21	237
Baltimore,	tof Hu Fiter	П	20a. Method of Disposition  1	Removal from State	20b. Pla cen	ce of Dispo netery, cren	sition (Name of natory or other p	lace)	6/4/	2012	20c. Location	n - City or To	own, State
tim	t. Pag tment tant; tjury o		4 Donation 5 Other (Speci	fy)	Sacr	ed Ht	. of Je				Dunda	11k. M	aryland
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at one.		21. Signature of Fune S rvice Lice	Michael I	\eise	r 22 D. 7	Name and Add uda-Ruc 922 Wis	dress of Fa k Fun e Ave	eral P. Dur	Home of	Dundal	k Inc	22
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused tone cause on each line.	the death.	Do not ente	er the mode of d	ying, such	as cardiac	or respiratory ar	rest,		Approximate Interval Between
-4	h sician/		Immediate Cause (Final disease or condition	Bact	ZVI	ial	Pne	um	oni	CL			Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):							
		ī.	Sequentially list conditions,	b. — Due to (ex ee e								-	
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	rice oi).							
	oe executed ician and burial-transit		that initiated events resulting in death) Last	C. Due to (or as a	conseque	nce of):							
0	s be exercised sician	ical		d									
376	ificate ig phy as th	Med	IF FEMALE:										
Box 68760	endir r use	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o			Ectopic pregna	ancy				Date of delive	*
Bo	deatl he att	sici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at g ☐ Unknown	time of dea	ath 5	Other (specify)				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Month	Day Year
P.O.	at the d by t detach	Ph	Part II. Other significant conditions of	ontributing to death bu	t not result	ting in the u	nderlying cause	given in P	art I.	23e. Did to	obacco use co	ntribute to th	he cause of death?
σ,	res th signe d be (	d by					, ,			1 🗷	Yes 2 □ No	3 Pro	bably 4 Unknown
ord	requi been shoul	lete								24a. Was	an 24b	o. Were auto	psy findings available
ecc	e law e has ige 2	m du								auto	osy ormed?	prior to co death?	mpletion of cause of
<u>=</u>	ifficat tor, pa		25. Was case referred to medical				.26	Place of I	Death (Chec	1 Yes	2 No	1 Yes	2 L No
Vita	ysicis s cert direct	O B	examiner? 1  Yes 2 No	Hospital:	nt 2 🗆 El	R/Outpatien	-	NA		ome 5 $\square$ Resid	dence 6 🗆 Ot	ther (Specify	0
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ion	eath. or; Af the fu	lfica	2 Accident Investigatio 3 Suicide 6 Could not be	n			M 1	☐ Yes 2	2 □ No				
Division of Vital Records,	al or Att s after d I Direct ed in by	Certificate: To Be	4 Homicide determined	28e. Place of Injur building, etc.	y - At hom (Specify)	ie, farm, stre	eet, factory, offic	e		28f. Location (S City or Tov		iber or Rural	l Route Number,
2	To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filed in by the funeral director, page 2 should be detached for use as the teachers.	Medical	(Check 2 Medical Exam		amination a	and/or invest	igation, in my op	inion, deat	h occurred a	at the time, date a	and place, and c	due to the cau	use(s) and manner stated.
D	o the	Σ	only one) 3 ☐ Certifying Nur 29b. Signature and title of certifier	se Practitioner: To the	best of my	knowleage,		nse numb		ace, and due to	ne cause(s) and 29d. Date sign		
	->F0		Datrien 8. (1	arwer, ms	, PhD	)	D	70	158	3	0		2012
-	ا د آ		30. Name and address of person who	completed cause of dea	ath (Item 2	3a) (Type, P				1.			
0+	1		DRadrien L.J					i Qu	are	DR B	alto	md	21237
	Sta		31. Date filed (Month, Day, Year)			for							
	Registr		MAY 3.1 2012	Beer	A.	J'EL							
DHN	ИН 17 Rev 06-	2011											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Items 23a,1 per dr.,g927,05/31/2012dhb

Certificate of Death

Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ronald Jerry Wylie Physician/ Month 2207 M Ma 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Howard County General Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** Min. JAN 3 Day, Hours 1 X M 2 - F Michigan 372-32-8290 77 1935 Director Usual Residence of Decedent 28a-f shov 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 X No Glenwood Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21738 USA 3574 Sharp Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Healthcare Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Cleta Fay Tuttle Andrew James Wylie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1612 Gablehammer Road Westminster, MD 21157 Rodney J. Wylie/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Gardens 5/21/2012 Marriottsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Se Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the sahould be detached 9 Unknown 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2. No 3 Probably 4 Unknown 1 \sum Yes certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 Yes ER/Outpatient 3 DOA Certificate: To 1 Inpatient 2 Z 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 00277 Ma 30. Name and address of person who comple cause of death (Item 23a) (Type, Print) Lane Columbia, Maryland 21044 (h.D. 575

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) **MAY 3 1** 2012

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep			2010	17100							
			Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Death	Reg. No.								
ı	Physicia Medic		Linda Susan Wilkerson		Month May	25, 2012	3. Time of Death  12:33 pM							
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death								
Sept.			11885 Rt 216	Fulton	8. Date of Birth	Howard								
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	Year) 9. Birthplace (State or Foreign Country) Maryland									
			Usual Residence of Decedent		000 107	7 1550   1101   1201								
	yland -f sho ed at	ctor	10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits							
	e Mar r 28a notifi	Dire	MD Howard Fulton  10e. Street and Number	10f. Zip Code			1 Yes 2 No							
	vith th	Funeral Director	11885 Rt 216	20759	"	0g. Citizen of What Cou U.S.A.	intry?							
	eath v	-une	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ameri	can Indian,							
98	fter de ', or if amine	by	1 X Never Married 2 ☐ Married  Armed Forces?  1 ☐ Yes. 2 X No  If Yes. Give	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White,	, etc.							
Ö	ours a Itural	Completed	3 Uvidowed 4 Divorced Year or Dates.			Specify: Whi								
75	72 he	mple	(Specify only highest grade completed) (Give	edent's Usual Occupation I kind of work done during most of work DO NOT use retired)	ng	16b. Kind of Business tr Howard Cou								
212	withir giene er tha , the I		Elementary/Seconday (0-12) College (1-4 or 5+)	nistrative Secreta	ry	Public Sch	ools							
nd	filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		ŕ								
Zla	uld be d Men narke natic	_	John D. Wilkerson	er										
Ma	2 shoth and the and traur	W Y	T T	City or Town, State, Zip	Code)									
ē,	f Heal item		20a. Method of Disposition 20b. Place of Disp			20c. Location - City or T	Fown, State							
E 0	Page nent o int: If iry or			matory or other place) el Crematory May	27, 12	Odenton, M	aryland							
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signaly re f Funderal Servi » Licens e M00773	2. Name and Address of Facility Donaldson Funeral	Home, P.	A.	707 4200							
	23a. Part 1. Enter the presence or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest													
ь	Pnysician/	ar a	shock, or hear fallule. List only one cause on each line.  Immediate Cause (Pinal disease or condition Cerebral Thalamic Infarct (CVA)											
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):	c illiaice (CVA)			5 months							
		r.	Sequentially list conditions, b. Cardiomyopathy											
	ed nsit	Examiner	If any leading 1 immunes, cause. Enter Underlying Cause (Disease or imply)  Hypertension											
	execut in and ial-tra	Exa	that initiated events c. Due to (or as a consequence of):											
09	cate be executed physician and the burial-transit	dical	d. Diabetes											
687	ertifica ding p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy											
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<u>~</u>	s that gned be det	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to t								
rds	equire een si nould	eted	Stage 4 Renal Disease		1 ∐ Ye	s 2 XINo 3 □ Pro								
9 0 0	has b	Completed	Hyperlipidemia		24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of							
Ě	in: The ificate or, pag		25. Was case referred to medical	26. Place of Death (Check	1 🗆 Yes 2		2 🗆 No							
Zita Zita	ysicia is cert direct	To Be	examiner? 1	LO4b		nce 6 Other (Specif	5/)							
ō	ng Ph fter thi meral		27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury		28d. Describe hov		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
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Division of Vital Records, P.O. Box 687	I or At after of Direct d in by													
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier  1 X Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or invest	stigation, in my opinion, death occurred at	the time, date and	I place, and due to the ca	ause(s) and manner stated.							
	othe vithin 2 omple	ž	only one) 3 $\sqcup$ Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number		ause(s) and manner as s								
	. > - 0		Bonnie Catalano Do	H0040518		iay 25, 201								
	10./		30. Name and address of person who completed cause of death (Item 23a) (Type,	,										
	101		Bonnie Catalano, D.O. 5450 Knoll No 31. Date filed (Month, Day, Year) 32. Registrary Signature		a, Maryl	and 21045								
	Stat Registra		31. Date filed (Month, Day, Year)  NAY 3 1 2012  Server 32. Registrary Signature  A graver											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Month Jimalou A. Whiting 21 11:45 PM Mav Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George Morningside House of Laurel Laurel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Min. Director 579-05-4229 1 🗆 M 2 🛛 F Mar 05, 1911 South Carolina 101 Usual Residence of Decedent 28a-f show items 23a or 28a-f shorer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7700 Cherry Lane 20707 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner þ 1 Never Married 2 Married X Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black "natural", 3 X Widowed 4 Divorced Completed Year or Dates 2 should be filed within 72 hours th and Mental Hygiene.
77 is marked other than "natura traumatic event, the Medical E. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Benson Agnew Lizzie Sitton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 si Health a tem 27 is Ruby M. Henley 13112 North Point Lane, Laurel, Maryland 20708 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If ite any injury or of ■ Burial 2 ☐ Cremation 3 ☐ Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 2012 Suitland, Maryland Signature of Funeral Service Lie 22. Name and Address of Facility
Donaldson Funeral Home, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. ediate Cause (Final M00773 Maryland 20707-4389 23a. Part 1. Enter the disease, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ heimers Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 🙀 No 2 X No 1 🗌 Yes Yes **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 □ Nursing Home 5 □ Residence 6 🗷 Other (Specify) Living 1 Yes Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After the in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

10V

Box 68760

P.O.

Records,

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

Jenny Moy, MD,

MAY 3 1 2012

31. Date filed (Month, Day

anny

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13952 Baltimore Ave.,

32. Registrar's Sanature

29c. License number

Laurel, MD 20707

D43260

29d. Date signed (Month, Day, Year)

May 22, 2012

2-03932				pe or Print i						egible.	е.		
oy Cassandra		ts 1- For State	St	tate of Maryla				nd Men	tal Hygiene		201	12 1710	
		Registrar	- (First \$4)-1-1	W- 1 1	Ce	rtificate	of Death		To 8-4-40	Reg. No.			
Physici Medical Exam		1. Decedent's Nam	CASSA	NDRA _	WAT	TS			2. Date of D Month May 23	Day 2012	Year	3. Time of Death 1545 hrs	
		4a. Facility Name ( Prince Geo		on, give street and nu	number) 4b. City, Town, or Location of Deal Cheverly				of Death		4c. County of Death Prince George's		
Funeral		5. Social Security N		6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye	ar If Unde	er 24Hrs. 8. Date of	1		•	
Director		217-70-5		1 M 2 X F	52		Months Da	_	Min. OCT.	19.	1959 Fore	Birthplace (State or eign WASHINGTON Country)	
		Usual Residence o		I WI ZELF			15.					DC DC	
any.		10a. State	10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits	
and f show	ō	MD	PRINC	E GEORGE	S	LANHA	M					1 X Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once.	rect	10e. Street and Nu	mber				10f. Zip Code		izen of What Co	ountry?			
th the 23a or notifie	Ö	8905 KE	EWATIN				207			US			
hours after death with the Maryland 'natural', or items 23a or 28a-f sh Examiner must be notified at once	<b>Funeral Director</b>	11. Marital Status  1 X Never Marrie	ed 2 M						gin? ( Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame White, etc.	erican Indian, Black,	
ter de		3 Widowed	4 Div	1 Yes vorced If Yes, Give Yee	2 X No	1	Yes 2 ▼ N	o specify:			Specify: BLACK		
ours at atural	d by	15. Decedent's Ed	ducation (Spe	or Dates: ecify only highest grad	de completed)		ent's Usual Occup			s/Industry			
2	Completed	Elementary/Seco	ondary (0-12)	College (1			most of working lift STAL WOR		use retired)	G	OVERNME	NT	
15-0036 Tiled within 72 Hygiene. If other than "	Ë	17. Father's Name	(Fi-4 \$4:44)				DITLE WOL		- M /Find Middle				
	BeC							LILI	s Name (First, Middl TE KENN		Surname)		
2121 2121 Mental Marked c cvent,	To B									ity or Town, Sta	ite, Zip Code)		
MD d 2 sho lith and in 27 is		JOSEPH P		II/SON		8905	KEEWATI	N ROAI	LANHAM,	1ARYL	AND 207	06	
t if te a		20a. Method of Dis		n 3 Removal fro		Place of Disp crematory or	osition (Name of cother place)	emetery,	Date	20c.	Location - City	or Town, State	
imore Pages 1 nent of H ant: If i		4 Donation 5	Other S	pecify:		VERDAL	E CREMAT	ORY	5/31/2012			,MARYLAND	
Baltimore permit. Pages 1 a Department of He Important: If it		21. Signature of Fu		Licensee	Divers.	22	. Name and Addre					AL HOME, INC.	
		23a Part L Enter th	_/_	complications that ca	aused the death	Do not ente						YLAND 20785  Approximate Interval	
Physician /Medical		failure. List on	ly one cause	on each line.				,,	and an incorporation y			Between Onset and Death	
Examiner		Immediate Cause ( or condition resulting			consequence of		rnage						
		Sequentially list co		b									
	Ē	if any, leading to immediate Due to (or as a consequence of):											
190 = =	Examiner	(Disease or injury to events resulting in			consequence o	f):			_				
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Box 68760, e death certificate be the attending physic of for use as the bur	Physician/Medi	IF FEMALE: 23b. Was decedent			outcome of pregi		Fetal death 3	Ectopic	pregnancy	23	d Date of delive Month	ery Day Year	
ox 687 eath certific attending p	icia	past 12 months			ant at time of de	ath T	Other (Specify)						
BO; he death y the ath	چ			ions contributing to				sinas is De	-11 22° Di	d tabasas	use contribute t	to the cause of death?	
res that the d signed by the				cocaine u		esulting in the	underlying cause	given in Pa				obably 4 🗸 Unknown	
rds, F requires been sign	Completed by	пурстес	101011,	cocarne a						as an	24b. Were a	autopsy findings available	
Cords law requi	힐								pe	topsy rform <u>ed</u> ?	death?		
tal Rec		25. Was case refer	ad to madica				26 Plac	o of Dooth	Check only one)	s 2 🗸 N	0 1 1	Yes 2 No	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	o Be	examiner?		Hospital:	npatient 2	ER/Outpatie		Other	Nursing Home 5	Reside	ence 6 Oth	er:	
n of \ding Phy.	-	27. Manner of Deat		28a, Date	of Injury Day,Year)	28b. Time o	f Injury 28c. Inj	ury at Work	? 28d. Describ	e how inju	ury occurred	· · · · · · · · · · · · · · · · · · ·	
ion tendir eath. tor: A	Certification:	1 X Natural 2 Accident	5 Pend		Day, roury		1	Yes 2	No				
or At or At after d Direct I in by	tific	3 Suicide	6 Coul	d not be 28e. Place	e of Injury - At ho	ome, farm, str	eet, factory, office	building, etc	28f. Location or Town		nd Number or F	Rural Route Number, City	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funcral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Š	4 Homicide		rmined (Specify)									
the He in 24 in pletely	cal	(Check only		hysician: To the bes miner:On the basis o									
To T Voiting	Medical	29b. Signature and		and manner st				se number				onth, Day, Year)	
	2.2			n/ 1	1		O.C	.M,E.		2.0	26, 2012		
1	ł	30. Name and addre	ess of person	who completed caus	e of death (Item	23a)							
$\forall$		Jack Titus N	ID. Dep	outy Chief Medic			Baltimore Str	eet, Balti	more, MD 2122	3			
S	ate	31. Make Yie 3 Mant	201 Zear)	Denew 32. Re	or rar's Sold								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:26 am **Physician** 2 a0%) /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Catonsville **Baltimore** Catonsville Commons If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F 91 Sept.20. Director 545-14-2806 1920 Texas Usual Residence of Decedent the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1200 Keithmont Road 21228 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 TNo Specify Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) ont of Health and Mental Hygiene.

If Item 27 is marked other than "nature or other traumatic event" (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technical Supervisor Roper Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Joseph Wendzinski Lalislawa Januchawski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2852 Lafayette Trace Drive; St. Cloud, FL Alicia Knothe Daughter 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I Important: If Its any Injury or or once. 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Atlantic Crematory 5/30/2012 4 □ Donation 5 □ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service License 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final hysician Conges disease or condition resulting in death) /Medical Due to (or consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes 2 No 1 □ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 24 hours a completely filled 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F within 2

State

Registrar

DHMH 17 Rev 1/2001

MD

29c. License number

29d. Date signed (Month, Day, Year)

ation Blud Gan Burnie MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1000 M 7012 MERKER A. YOUNG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIT Huspitu Bultimort Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-50-4889 Hours Director 1 ▼ M 2 □ F 10-6-1949 MARYLAND show 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No 28a-f MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? by Funeral 21239 USA 1623 WINFORD RD or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces

1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify BLACK Specify: "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) HOBERSON AND WALKER LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပု VIOLA BRANDT NORMAN YOUNG SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1623 WINFORD RD. BALTIMORE, MARYLAND 21239 BESSIE &LAYBORNE (SISTER) atient 20a. Method of Disposition 1 ☐ Burial /2 ☒ Cremati 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) METRO CREMATORY 5-30-2012 BALTIMORE, MARYLAND 21. Signature of Europal Segret Licensee JONATHAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Par 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Small Physician/ disease or condition resulting in death) 211 month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as the IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) been signed by the s should be detached P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 Yes 2 N Yes 2 Division of Vital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manne f Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at within 24 hours after death. To the Funeral Director: After iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and litle of certifier Date signed (Month, Day, Year) MI 000 Name and address of person who completed ause of death (Item 23a) (Type, Print) Sinal Mospita aomino

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Elizabeth Agnes May 2012 7:09 p<sup>M</sup> Abbott /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Chesapeake Woods Center Dorchester Cambridge 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F Months Days Hours **Director** 482-07-4420 95 April 6, Nebraska Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the invition Examiliar must be notified at 10d. Inside City Limits Director MD Dorchester 1 √ Yes 2 No Cambridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Glenburn Avenue 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 🛣 No Specify white þ 3 X Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) medical secretary 11 hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 Is marked of Ephraim Fahnestock Marie A. Sawyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Hanson 22 Dorchester Ave., Cambridge, MD son Baltimore, Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dorchester Mem. Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/12 Cambridge, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. any 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician dementia disease or condition resulting in death) HEAKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Il-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed ng physiclan ar Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ⚠No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Ö s been signed by the should be detached 9 Unknown 9 Unknown ۵. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Completed 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 1 Yes 2 No this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitai: 2 No ဥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Johnson 100

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 0035 M Emma Jean Adkins 2012 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death Examiner HICOMICO PO1192 3HV13b414 IBIDNAL 1 Year If Under 24 Hrs Age (In yrs. last birthday) If Unde 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Days 222-22-9735 Director 73 1 M 2 X F Nov. 30, 1938 Delaware 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 X Yes 2 No Seaford Sussex 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 19973 511 Yorktowne Lane U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black White etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Yes 2 XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify "natural" Completed 3 X Widowed 4 Divorced white Year or Dates and Mental Hygiene.

is marked other than "naturaumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 seamstress garment company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ of Health and Menta fitem 27 is marked rother traumatic e Martha Elizabeth Wilkerson Leon David Wilkerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith L. Adkins 29026 Ponderosa Avenue Laurel, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Laurel Hill Cemetery May 9, 2012 Laurel, Delaware Name and Address of Facility
Short Funeral Home
13 East Grove Street e of Funeral Service License wil Delmar, 23a. Part 1. Enter the di shock, or heart fail ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death re. List only one n each line Immediate Cause Fina Physician/ disease or condition resulting in death) Medical Due to (or as a confequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? ō Year 5 Other (specify) Month Dav Pregnant at time of death signed by the at the detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' After this certificate 1 Yes 2 No Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Impatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? after death. 2 🗌 No Accident Suicide Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to within 2 To the only one) Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mobite 0 actorn Sho filed (Month, Day, State

Registrar

MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Leroy Adams Month Robert 1217 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death REGIONAL MADIMI 542136419 AICOMICO CENTU TENINSULA Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 215-20-7448 **Director** 1 X M 2 D F 84 10/09/1927 Maryland Usual Residence of Decede show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Delmar 1 Yes 2X No Delaware Sussex 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral **23**a 19940 USA 37239 Carr Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces Black White etc. 9 Completed by 1 Never Married 2 Married X Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: n res, Give Year or Dates:**Army** "natural" Specify: 3 X Widowed 4 Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mobile Home Park Maintenance Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Goldie Esther Ruby Robert Leo Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virgil E. Adams / Son if Health 37239 Carr Blvd., Delmar, DE 19940 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of Important; If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State Springkill'n Mellory 5/14/2012 4 Donation 5 Other (Specify) Hebron, MD <u>Gărdens</u> Holloway Funeral Home Professional Association CFS 501 Snow Hill Rd., Salisbury, MD 21804 Dompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): yocardial Inforction burial-transi Cause (Disease or injury that initiated events resulting in death) Last eles and Due to (or as a consequence of): attending physician Physician/Medical eumonia Box 68760 use as the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death the 9 Unknown 9 Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death s after death. I Director: After the Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of M	aryland		artment o tificate o		and M	_	giene Reg. No. 2 (	)   2	17200	
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-14	Medic Examir		4a. Facility Name (if not institution, g	ive street and number)			4b. City, Town	, or Location	of Death	HpRil.	28 a	of Death	21:00 M	
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	yland if show ed at	tor	10a. State 10b. County			Town or Loc						1	0d. Inside City Limits	
	ne Mar or 28a notifi	Dire	MARYLAND WICOM:	LCO	W.	ILLARI	OS 10f. Zip Code	<u> </u>			40. 000	1 ★ Yes 2 □ No Citizen of What Country?		
	ith with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	7320 CANAL STR	EET			218				USA	·		
980	s after dea ral", or ite Examiner	ρ	11. Marital Status 1 ☐ Never Married 2 🄀 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Be Armed Forces? 1 1 Yes 2 Xill If Yes, Give Year or Dates.		If	Vas Decedent o Yes, specify Cu	uban, Mexicar	n, Puerto P	ify Yes or No- lican, etc.)		Race - American Indian, Black, White, etc. ecify: WHITE		
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212	within 72 rgiene. ner than t, the Me		Elementary/Secondary (0-12)	College (1-4 or 5	5+)		O NOT use retire HOMEMAKI	,			OWN	HOME		
Maryland 21215-0036	요수수를	To Be	17. Father's Name (First, Middle, Las ASBURY I	EWIS				i	er's Name ELIMA		Maiden Surnam	e)		
<b>J</b> ary	should be file and Mental is marked or aumatic eve		19a. Informant's Name/Relationship			19b. Mailin	g Address (Stre			-	r, City or Town, S	State, Zip (	Code)	
	and 2 Health tem 27		E. HOMER ADKINS	'HUSBAND	20h Pla		CANAL Sition (Name of	STREET,		LARDS,	MARYLAN			
Baltimore,	Page 1 ment of ant: If i		1 X Burial 2 ☐ Cremation 3 4 ☐ Dopation 5 ☐ Other (Spe	Removal from State	cen	netery, crem	CEMETE		5/4/			tion - City or Town, State  LLARDS, MARYLAND		
Balt	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Lice	ensee	ty		BYVILLE							
	23a. Part 1 Enter the disease, or complications that cause the reach. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on sch line.  Physician/  Immediate Cause (Final disease or condition												Approximate Interval Between Onset and Death	
4	Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):								
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200	ate be	edica		d						-			<del></del>	
. Box 687	ath certif attending for use a	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal c	death 3 🗌	Ectopic pregna Other (specify)				1	ite of delive	ery Day Year	
ds, P.O.	requires that the des been signed by the s should be detached	ed by Pł	Part II. Other significant conditions - Septic Shock			ting in the ur	nderlying cause	given in Part	1.				ne cause of death?	
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Division of Vital	I or Attending Physician: The la after death. Director: After this certificate ha in by the funeral director, page i	Certificate:	2 Accident 3 Suicide 6 Could not 4 Homicide determine	8f. Location (S City or Tow	treet and Numbern, State)	er or Rural	Route Number,							
Ω	Hospital 44 hours a Funeral I tely filled	Medical	(Crieck Z L Medical Exa	ysician: To the best of miner: On the basis of e	kamination a	ind/or investi	dation. In my on	inion, death oc	curred at t	ne time date a	nd place, and due	e to the cal	ise(s) and manner etated	
	To the within 2 To the comple		only one) 3 ☐ Certifying No 29b. Signature and title of certifier	urse Practitioner: To the	e best of my	knowledge,	death occurred a	at the time, dat nse number	te and plac	e, and due to the	ne cause(s) and n	nanner as s	tated.	
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	GTC		30. Name and address of person who	Completed cause of de		3a) (Type, Pr 100 &	int) AST	CARRO	OIC	STRE	ET, SAC.	ISBUR	1,40,21804	
	Stat Registra	٠ ا	31. Date filed (Month, Day, Year)  MAY 1 2	012 Annu		. pa	ald							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 6:25 A M IRIS MARIE BUNDICK May 10 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5300 Tulls Corner Road Marion Station Somerset Social Security Number If Under 1 Year If Under 24 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours 212-06-3983 Director 83 Maryland Yrs 05/26/1928 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Maryland Somerset Marion Station 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5300 Tulls Corner Road 21838 U.S.A. 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental I 7 is marked o ည William Frank Muir Lillian Priscilla Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 George B. Windsor (Son) 5300 Tulls Corner Road - Marion Station, MD 21838 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) artment of injury or St. Pauls Cemetery 05/12/2012 Marion Station, MD 21. Signature Furreral Service Licensee Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Per Per Robert H. Bradshaw Jr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between BREBRO VASCULAR Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CUI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami requires that the death certificate be executed Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as the IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ō in the past 12 months? 5 Other (specify) Month Day Year ed by the a ☐ Yes 2 1 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiper? Other: 4 \( \text{Nursing Home} \) 5 \( \text{HAesidence} \) 6 \( \text{Other} \) Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 I DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 05-14-2012 2556 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ballard Sr. John Wesley 959 2012 Medical 05 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NICOMICO 544156484 MediCAL CENTA RPGIONAL 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 218-20-6933 Hours 1 **№** M 2 🗆 F **Director** Maryland 28a-f shov with the Maryland 10b. County 10c. City, Town or Location Director be notified Princess 1 Yes 2 No Anne Somerse Maryland 5 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral 2185 11374 U.S. School Greenwood Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give | 943-14 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian o, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 res, Give 1943 - 1945 Year or Dates. 1 ☐ Yes 2 🕅 No Specify Black "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Somerset County Bol at Ed Contractor Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ၉ ent of Health and Mentant: If item 27 is marked y or other traumatic ev Ballard Benjamin Hay Ward usan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette L Chester field Ln. -awrence-daughter 782 Salisbury 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: I any injury or 5-14-12 Veterans Cerneter Hurlock 4 ☐ Donation 5 ☐ Other (Specify) mD, 2184 Signature of Funeral Service Licensee Anthony E Princess Anne, MD 21853 tampden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph<sub>sician/</sub> disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last igned by the attending physician be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live Birth 2 ☐ retail do... 4 ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Dav Year g 🗌 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Nhknown page 2 should peen Were autopsy findings available 24a. Was an has prior to completion of sause of death? hours after death. uneral Director: After this certificate 1 Yes 2 1 completely filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No 1 💆 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHOPE PR, SALISBURY, MD

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

nanes ballaru		1-For State Certificate of Deal			No.	
Physicia	ın/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	av Year	3. Time of Death
Medical Exami			Town or Location of Death	May 4, 2012	100-	1914 hrs
					Somerset	
Funeral		The state of the s	2 Date of Death   May 4, 2012   Year   3. Time of Death   Ye			
Director		143-64-1430 1×1 48 Yrs.	is Days Hours Will.	July 7,		
Ana Ana	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	5	MD Somerset Upper	Fairmour	\ <del>+</del>		1 Yes 2 No
Maryland r 28a-f show	Director	10e. Street and Number 10f. Zip	p Code	10g.	- 0	ry?
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked taker than "natural", ur items 23a or 23a-f abounsatic event, the Medical Examiner must be notified at once.	- 1			cify Yes or No-	<u> </u>	an Indian, Black.
leath w	Funeral					
after c	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	1	, , , , ,		
2 hours					od, Kind of Business/In	dustry
OO36 within 72 giene.	Completed		borev		Perdue	Inc.
15-00 filed wit Hygien of other		17. Father's Name (First, Middle, Last)			_	. )
21215-0036 Jud be filed within 7 I Mental Hygiene, i marked inher than ie event, the Medica	o Be		s (Street and Number or Ru	ıral Route Numbe	r, City or Town, State,	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked rither than "natura injury or other traumatic event, the Medical Exami		Bonita Ballard - Wife 8391 U	pper Hill Rd.	Upper fr	airmount, n	D 21867
of Heal		1 M Burial 2 Cremation 3 Removal from State crematory or other place	) , , , , , , , , , , , , , , , , , , ,	Date 2	Oc. Location - City or T	own, State  Anne, MD
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tri						
Balti permit. Departu Imports			9 Hampdon	Ave D	non cess A	nne.m) 21852
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	of dying, such as cardiac or	respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/* /Medical Examiner		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascu	ular Disease			Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	<u>ine</u>	if any, leading to immediate Due to (or as a consequence of):				
d Sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
xecute n and I - tran	E E	d. UNPENDED AMENDED				
(68760, certificate be executed ending physician and ase as the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
lox 6876 eath certificat e attending phi	lan/	23b. Was decedent pregnant in the past 12 months?	_	су	Month Da	ay Year
Box 687 e death certifice the attending pled for use as th	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	(HOITY)			
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.			
rds, Prequires to been sign hould be o	De la					
Cords, law requir	Completed			autopsy performe	ed? death?	·
of Vital Records, og Physician: The law requir Uther this certificate has been soneral director, page 2 should incral director, page 2 should		25, Was case referred to medical	26 Place of Death (Check or		No1 ✓ Yes	2 No
Vita hysicia this cel	o Be	1 V res 2 No	DOA Other Nursing	Home 5 Re	sidence 6 Other:	
ਵਜ਼ੀ , `ਵੀ	<u> </u>	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how	v injury occurred	
Division tal or Attendi as after death.	Cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factor		28f. Location (Stre	et and Number or Run	al Route Number, City
Div	Certification	3 Suicide 6 Could not be determined (Specify)		or Town, State	e) 	
Division  To the Hospital or Attenwihin 24 hours after death To the Funeral Director:						
To To	Medical	and manner stated.	Oc. License number	2	9d, Date signed (Mon	th, Day, Year)
		0-0-	O.C.M.E.	M	May 6, 2012	
		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Ba	altimore Street Raltim	ore MD 2122	93	
S	ate	31. Date filed (Month, Day, Year) 37 Registrar's Signature		V. 0, 1810 2 122		
Regis						
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itate of Maryland / Department of H	lealth and Mental Hygiene 2

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year **Physician** 1509 Ralph Baldwin, Sr. 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1018 Lynhaven Drive Worcester #501 Pocomoke If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F Yrs. Director 242-66-3995 10-4-1936 NC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits •how rthen "naturel", or Iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No **Funeral Director** MD Worcester Pocomoke 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Victoria Apt. 1018 Lynhaven Drive #501 21851 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Speci Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Worcester County al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian School System 12 Pages 1 and 2 should be filed vitment of Health and Mental Hygie tent: If Itam 27 is marked other toury or other treumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Mae Baldwin Walter Blue ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C2v4) 851 1018 Lynhaven Dr, Apt #501, Pocomoke, MD Annie Baldwin/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of I
Importent: If its
eny Injury or ot
ance. 1

Burial 2 □ Cremation 3 □ Removal from State Mt. Hope Bapt Cem 5-12-2012 Stockton, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 917 W. Isabella St. Ignature of Funeral Service Licensee Funeral Home Salisbury, MD 21801 24 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury Medical Certification: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ng physician as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Month in the past 12 months? Dav Year signed by the a 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the t 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? (ostate C.A 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No : After this certifice of funeral director, p Hospital or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in the Completely filled in t 1 Pfritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) H50497 7MF 2012 STO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) salis bu 21801 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0750AM Linda Lou Burns Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Reg. Med. Ctr. Allegany Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) 234-64-2809 Director 1 🗆 M 2 💢 F 68 May 24,1943 Usual Residence of Decedent Keyser, WV 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 No WV Mineral Keyser 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 26726 66 Fort Avenue USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working nit. Page 1 and 2 should be filed within 7; artment of Health and Mental Hygiene. octant. If item 27 is marked other than injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary County School System Be 17 Father's Name (First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Arthur Wiltison Audrey Elizabeth Varieru 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is n Walter P. Burns/Husband 66 Fort Avenue Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1  $\square$  Burial 2  $\overline{\mathbb{X}}$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) cemetery, crematory or other place) 5/24/12 Smith Funeral Home Crematory Keyser, WV 21. Signature of Funeral Service Licen e 22. Name and Address of Facility 85 S. Main Street Smith Funeral Home Keyser, WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MULTIPLE ORGAN SYSTEM FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ENDO CARDITIS INFECTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed BLOOD STREAM INFECTION Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death Unknown 1 ☐ Yes ∠ ₩ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renay Congestive Heart Failure Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed Disseminated Intravascular Were autopsy findings available prior to completion of cause of Interstition Lung disease, 24a. Was an sate has autopsy performe death? Cougulopathi 2 🗌 No 25. Was case refe d to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{PResidence} \) 6 \( \text{Other (Specify)} \) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA a Hospita. ... n 24 hours after deatn. The Funeral Director: After th funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Amit Blundari D0071867. 118/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Western Maryland Health System, 12500 Willow Brook Rd, Cumbally

State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 2012 5 6 8:45 p Samuel Stanford Crawford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fruitland Wicomico 102 Pine Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth
| Hours | Min. (Month, Day, Year) 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Yrs. Director -22 - 1923MD 219-07-1372 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County and marked other than "natural", or Iteme 23a or 28a-f show 'is marked other than "natural", or Iteme 23a or 28a-f show reumatic svent, tra Medical Examinar must be notified at 1 Yes 2 No Directo MD Wicomico Fruitland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA Funeral 102 Pine Street 21826 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after Timed Forces? 1 □ Yes 2 □XNo If Yes, Give Year or Dates: 1 Never Married 21X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Sped lack ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Supervisor Salisbury University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental Heant: If Item 27 is marked off jury or other traumatic even Be ပ္ Unk Ida Stanford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Pine Street, Fruitland, MD 21826 Joyce Rozelle/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or Cottage Grove Cem 5-12-2012 Westover, 4 ☐ Donation 5 ☐ Other (Specify) Bennie Smith W. Isabella St. 21. Signature of Funeral Service Licensee Funeral Home Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Cerebro vas culer accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension S- uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 D No : After this certification : Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Tyes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funers! Director: A 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. ü 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05/08/12 068222 30. Name and address of person who completed use of death (Item 23a) (Type, Print) SALISBURY 1415 5. DIVISION 57 STE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 | 7208 12-03536 Gordon Chance 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 7, 2012 Gordon Oliver Chance Medical Examiner 1233 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. 215-56-1335 Director 1 X M 2 F c Maryland 64 Yrs 03/15/1948 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b Count 1 Yes 2 X No Maryland Wicomico Parsonsburg Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8599 Pittsville Rd 21849 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 X Married 2 X No Yes 4 Divorced If Yes, Give Year White 3 Widowed 1 Yes 2 x No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mechanic Equipment Repair 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Samuel Grayson Chance Be Josephine Morris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina E. Chance/wife 8599 Pittsville Rd., Parsonsburg, MD 21849 ent of Health a nt: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 5/12/2012 Salisbury Crematory Donation 5 Other Specify: Salisbury, MD 22 Name and Address of Facility Home Professional Association Service Licensee Compson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause, Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last hysician/Medical UNPENDED **AMENDED** ned by the attending physician detached for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.0 靣 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? page 2 No Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural Division Pending 1 Yes 2 No the Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) e Funeral I determined (Specify) Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Within 2 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registra

OCME

2012

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Victor Weedn MD JD

31. Date filed (Month, Day, Year

**ORIGINAL** 

29c. License number O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

May 8, 2012

	· Cu	1- For State	e of Maryland /	ck Indelible Department Certificate	of Health	and N		ygiene		201	2 172		
Physicia		1. Decedent's Name (First, Middle,L	ast)					2. Date of De			3. Time of Death		
ical Exami	ner			am				Month May 4, 20		Year	1814 hrs		
		4a. Facility Name (if not institution, g Peninsula Regional Med			4b. City, To Salisbu		ation of Death	1		c. County of Dea Wicomico	th		
Funeral				(In yrs. last birthday			Under 24Hrs	. 8. Date of B	- 1		irthplace (State or		
Director		428-02-2523 11 Usual Residence of Decedent	X M 2 F	54	Yrs. Months		Hours Min			Fore	ign ount:Mississipp		
		10a. State 10b. County	1	0c. City, Town or Lo	ocation						10d. Inside City Limit		
be di	<u>.</u>	MD Wicomico		Salisbur	7						1 X Yes 2 N		
Maryland 28a-f show d at once.	Director	10e. Street and Number		Dalisbui	10f. Zip C	ode			10g. Ci	tizen of What Co	untry?		
the M	Dir	827 Church Stree	et		21	801			U	ISA			
Definition of the National Action of the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f should by or other traumatic event, the Medical Examiner must be notified at once.	<u>la</u>	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent	of Hispani			0-		Race - American Indian, Black,		
death or iter	Funeral	1 Never Married 2 Marrie	Armed Forces?	No No	If Yes, specify	Cuban, Me	xican, Puerto	Rican, etc.)		White, etc.			
after ral", iner	by		ed If Yes, Give Year or Dates:	0 1	Yes 2					Specify: B	lack		
hours		15. Decedent's Education (Specity		durin	dent's Usual Od g most of worki				16b.	Kind of Business	/Industry		
un 72 han	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+								. /		
d with giene ther t	E	10th 17. Father's Name (First, Middle, La	st)	L.	aborer	18.M	other's Name	(First, Middle,			n/Construct		
e file tal Hy ked o	-	Andy Cunningham						nne Tal		r ouriditio)			
Men Men C cvc	10	19a. Informant's Name/Relationship	(Type, Print )	19b. Ma	iling Address	(Street and	Number on F	Route Nu	mber, C	city or Town, Stat	e, Zip Code)		
d 2 should be filed within 7 lth and Mental Hygiene.  17 is marked other than numatic event, the Medica		Derrick Williams	/ Son		Old Wr								
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ath ce attend or use	Sici	1 Yes 2 No 9 Unknow	4 Pregnant at tin	ne of death 5	Other (Specify	<i>)</i>							
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ding Physician: The law requires that the death certificate be executed h.  After this certificate has been signed by the attending physician and sinneral director, page 2 should be detached for use as the burial - transit	百	Tata outsi sigimican condidone	contributing to death b	di noi resulling in ti	ie underlying ca	ause given	m Part I.	_	_		bably 4 🗸 Unknown		
equire een si	ted					-	_	24a, Was	an	24b. Were a	utopsy findings availabl		
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B Physician: The law requires that the three that the three	Completed			Ę.				1 ✔ Yes			es 2 No		
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Phys er this ral di	on: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ✓ ER/Outpati 28b. Time		a. Injury at \		g Home 5 28d. Describe		ence 6 Othe	er:		

Division

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: / completely filled in by the fu

Medical Certificat

State Registra

Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

OCME

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner Mary G. Ripple MD.

31. Date filed (Month, Day, Year)

O.C.M.E.

May 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Month Physician/ Maurice Glenn Clark, Jr.  $P^{M}$ Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1014 Union Ave. Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 216-88-6473 49 Maryland **Director** 1 🔀 M 2 🗆 F Nov. 9, 1962 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland must be notified at Director 28a-f Baltimore 1 X Yes 2 No Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5 21211 USA items 23a 1014 Union Ave. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces? ь þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Legg Mason Account Executive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Arlene Doris Biottenberger Maurice Glenn Clark, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 315 Kolbe Rd., Westminster, MD 21157 Maurice Glenn Clark, Sr./Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2X Cremation 3 Removal from State ō Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 05/23/2012 | Hampstead, Maryland Printer Aftererally Home and Chapel, P.A. 21. Sign ture of Funeral Service Aicensee 412 Washington Rd., Westminster, MD 21157 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Peath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Insulin-defend Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine ind use as the burial-transit an and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has death?
1 Yes 2 No 1 ☐ Yes 2 ☐ 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred tural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 057169

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

May 23, 2012

Letherille, M 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month Lauren Adams Colby, Jr. May 22. A M 8:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8022 Fieldstone Drive Frederick Frederick . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours New York April 23, 1931 Director 093-26-4459 1 X M 2 □ F 81 or 28a-f show 10b. County filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 8022 Fieldstone Drive 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other treumatic event. The Marian once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Attornev Law Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lauren Colby, Sr. Sarah Decker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristine Colby / Wife 8022 Fieldstone Drive, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory May 23, 2012 Smithsburg, Maryland 21. Signardre of Funeral Service Licensee 22, Name and Address of Facility Keeney & Basford P.A. Funeral Home M01612 106 E. Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by blood Pressure 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes 2 No director, B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 욛 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on and title of certifier 29b. Signation 29d. Date signed (Month, Day, Year) MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2170 Thomas Thonson 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Angelina Marie Cu	1.	For State	State	e of Maryland		rtment of tificate of		and Ment	ai riygiene	Reg. No.	20	12	1721
Physician		e <b>gistrar</b> . Decedent's Name							2. Date of D Month		Year		of Death 2 hrs
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	4	la. Facility Name (if 2120 Bell Tre		ive street and number	)	4	Waldorf	i, or Eocation of	Dodin		Charles		
Funeral		5. Social Security Nu		Sex 7. A	ge (In yrs. la	ast birthday)	If Under 1			Birth (MM/	(DD/YYYY) 9. B Fore	irthplace (S	State or
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varyland 28a-f show	ġ.	MD 10e, Street and Num			WA	HDORE	10f. Zip Co	de		10g. Cit	izen of What Co	untry?	
or 28	Director	2120 BE		EE LANE			20	0601		τ	U. S. A	A .	ļ
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cord law re- has be	Completed	l <del></del>								utopsy erformed es 2	? death	?	2 No
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should	Certification:	3 Suicide	6 Could	not be	r Injury - At	потте, тапті, вич	eet, lactory, t	office building, e		vn, State)			
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		4 Homicide	Certifying Ph	veicien: To the hest o	f my knowle	dge, death occ	urred at the t	ime, date and pi	ace, and due to the	cause(s)	and manner as s	stated.	
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F. 3 F. 8	¥	29b. Signature and	title of certifier					License number			d. Date signed ( ay 19, 2012	Month, Da	y, Year)
		( la	Scheu	9)				O.C.M.E.		IVI	ay 13, 2012	_	
p/		Laron Lock		who completed cause sistant Medical f	of death (Ite Examiner	em 23a) 900 W. E	Baltimore	Street, Baltin	more, MD 2122	:3			
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**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Walter Saunders Dickerson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner REGIONAL VICOMICO SAL156414 MediCAL TENINSULA Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 214-34-7827 1 X M 2 D F 75 Aug. 27, 1936 Maryland Usual Residence of Deced and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Wicomico Salisbury 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 105 Time Square 21801 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. Yes 2 No Yes, Give 105 1 Never Married 2 Married ģ Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify. rr Yes, Give Year or Dates 1954-57 3 Widowed 4 X Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) bricklayer construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Parks John T. Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health a tant: If item 27 is 3001 N. Skipjack Dr., Cambridge, MD Donna Dickerson daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of Important: If it any injury or o cemetery, crematory or other place. 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veterans Cem, 5/22/12 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. ure of Funeral Service Licensee 700 Locust St., Cambridge, MD < Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic obstructive bulmonary disease or condition Medical resulting in death) Examiner Congertive Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown g Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the state of the state o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 2 1 🗌 Yes 1 Inpatient 2 SER/Outpatient 3 IDOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28d. Describe how injury occurred 1 🙇 Natural 5 Pending injury Investigation Accident 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To t. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 068222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

RAZA

31. Date filed (Month, Day, Year)

**資AY 21** 

HFZAL

32. Registrar's Signature

SALLSBURY Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05 Harold Webster Dailey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Wicomico alisbur **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days (Month, Day, Year) Hours Country) Director 402-18-4349 1 🕱 M 2 🗆 F 92 April 5, 1920 Kentucky 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Delmar 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21875 U.S.A. 8702 Mar-Lynn Drive death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 72 hours after X Yes 1941 1 Yes 2 X No Specify. than "natural", 3 Widowed 4 Divorced white Year or Dates 1945 traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12 truck driver petroleum is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Duard Dailey Laura Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 8702 Mar-Lynn Drive Delmar, MD 21875 Shirley Coffin Dailey (Wife) permit. Page 1 and 2 Department of Healt Important: If item 2 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State lo, cemetery, crematory or other place) May 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens Hebron, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street any Delmar, DE 23a. Part Enter th shock, or hear e disease, or failure. List o ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) I-transit Due to (or as a consequence of) resulting in death) Last the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? signed by the atter Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Yes 2X No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 XI No Other: 1 Yes မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending after death. 1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) Signature and title of certifie 05/07/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 045, 106 MILHOID MAY 10 2012 32. Registrar's Signature

Registrar

			Pleas	se Type or Prin							egib	le.			
	1		1 - For State Registrar	State of Ma	aryland /	Departme Certifica		lealth and N Death	nental Hy	GIENE Reg. No.	20	12	172	15	
			Decedent's Name (First, Middle,	Last)					2. Date of De				3. Time of D	eath	
	Physicia		Leroy All	en Ecks	tine				A pr	27	20	ear	4:15	AM	
i Ar	/Medic Examin		4a. Facility Name (If not institution,			4b. Ci	ty, Town, o	r Location of Death	eath 4c. County of Death						
G.			Western Maryla	and Hospital	Cente:			rstown	Washington						
	Funeral			4 M 2 M E	e (In yrs. last b	Month	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di April2	th ay, Year)	Year) 9. Birthplace (State or Foreign Country)				
١.	Director		214-34-7583	X 8	4	Yrs.		<u> </u>	Apri 12	2,192	8	Mary	land		
	and wo		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location						10	d. Inside City	Limits	
	Maryl f sho ied a	Į.	Md. Washi	ngton	Had	gerstown	1						1 □ Yes 2	-XNo	
	r 28a	irec	10e. Street and Number				Zip Code			10g. Citizen of What Country?					
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show with the Medical Examiner must be notified at	Funeral Director	20301 Lehmans N	Mill Rd.			21	.742			U.S.	Α			
	ems :	ner	11. Marital Status	pecify Yes or No Rican, etc.)	D- 14	America White, e									
õ	or it	by Fu	1 Never Married 2 Marri			Specify:	Whi	+ -							
2-003a	hours tural"		3 Widowed 4 □ Divorced	Year or Dates:	16	a. Decedent's U	A Isual Occur	nation		16b. Kind	d of Busi	iness/Indu			
<u> </u>	n 72 i "nat ledic	Completed	15. Decedent (Specify only highes	t grade completed)		(Give kind of life. DO NO	work done	durina most of worl	king				,		
7	iene. r thar	E O	Elementary/Secondary (0-12) College (1-4or 5+)  Stock Person Refr												
2	e filed ii Hyg other	BeC	17. Father's Name (First, Middle, Last)												
<u>a</u>	uld bu Ments rrked rrked	ToE	Roy A. Ecksti	inger											
Mar	2 sho and 1 Is ma auma	ľ	19a. Informant's Name/Relationsh	or Town, State, Zip Code)											
e, ≥	and lealth m 27 her tr		Allen E. Ecksti	ine (Son)	20h Plane	)211 Leh	mans_	Mill Rd.	Hagers Date	town,	Md.	2174	2 vn State		
0	ges 1 If of H If Ite or ot		1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Smithsburg Cemetery 2012  Smithsburg Cemetery												
Baltimor	t. Pa ntmer rtant: njury														
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee MO1414 J.L. Davis Funeral Home 12525 Bradbury Smithsburg, Md.												
	-		23a. Part1. Enter the disease, or	complications that cause	d the death. D	o not enter the r	node of dyir	ng, such as cardiac			burg		Approximate Interval Between	200	
	Physician	0.1	shock, or heart failure. List Immediate Cause (Final	only one cause on each I	me tati	bone	can	cer					Onset and De	eath	
ř	/Medical		disease or condition resulting in death)	Due to (or as	a consequenc	e of):	4					-			
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οχ/ ο	physicate the l	gi		d											
	requires that the death certificate be een signed by the attending physicia nould be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						2	3d. Date	of delive	ry		
ROX	atter d for u	ciar	in the past 12 months?	4☐Pregnant a	2 ☐ Fetal dea at time of death		c pregnanc (specify) _	;y 			Mon	th	Day Ye	ear	
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,, J	w requires that the de been signed by the a should be detached	by P	Part II. Other significant condition	ons contributing to death	but not resulting	g in the underlyir	ng cause giv	ven in Part I.					e cause of de		
ğ	en sig	ed	Vrahete	g menis	ng				1	]Yes 2[	]No :	3 🗌 Proba	ably 4 dor	ıknown	
Records		Completed	Hypert	s mellet					24a. Wa	opsy	24b. W	ere autoprior to con	osy findings av	vailable use of	
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	After unera	ü.	27, Manner of Death  1 Natural 5 □ Pendin	28a. Date of Inj (Month, D		b. Time of Injury M	28c. Inju Wo	iryat ork? ]Yes 2∐No	28d. Describe	e now injury	Occurre	eu			
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2	after a	ertif	27. Marrier of Death  1 Natural 1												
_	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifyir	ng Physician: To the bes	t of my knowled	dge, death occur	rred at the t	ime, date and place	e, and due to th	e cause(s)	and mar	ner as st	ated.		
	n 24 h	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s		and/or investiga	ation, in my	opinion, death occi	urred at the tim	e, date and	place, a	na aue to	tne cause(s)		
	To the within To the comp	Me	29b. Signature and title of certifie	Λ	M-D		29c. Licens				-		Day, Year)		
			1 Layle	+ 1	VV(-1,7			041131				01	2012		
	51		30. Name and address of person	who completed cause of	death (Item 23	a) (Type, Print)		00 Pennsy			ıe				
		o to	31. Date filed (Month, Day, *ear)	, ,	trar's Signature	·		gerstown,	, MD 21	142					
	St Regist	ate rar	MAY O 1			Buch	フ								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Fields Marie Evans ам Medical May 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13681 Crows Foot Lane Princess Anne Somerset 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) **Director** 218-12-1538 1 M 2 X F 87 10/29/1924 Maryland Usual Residence of Deced or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset Princess Anne 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21853 13681 Crows Foot Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ R. Clyde Smith Betty Mae Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13681 Crows Foot Lane, Princess Anne, MD 21853 Trudy L. Fitzgerald/Daughter Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 5/8/2012 Salisbury Crematory Salisbury, MD Donation 5 Other (Specify) 21 Signal Service Licensee HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 74 pompou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to for as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 🗷 To Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) SIC who completed cause of death (Item 23a) (Type, Print) 30. Name and addr DE 31. Date filed (Month, Day, Year) 32 Registrar's Signa State MAY 2012 Registrar

Registrar

DHMH 17 Rev 06-2011

State

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>Fitzge</u>rald 1721 M Almeta Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death KRIONAL HICOMICS TENINSULA ocial Security Number 6 Sex If Under 1 Year If Under 24 Hrs **Funeral** . 9. Birthplace (State or Foreign Country) 8. Date of Birth Months Days Hours (Month, Day, Year) **Director** 168-46-0270 Usual Residence of Decedent 1 🗆 M 2 😿 F 59 02/26/1953 Pennsylvania 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Wicomico Salisbury 10f, Zip Code 10g. Citizen of What Country? Funeral 521 Alabama Avenue. 21801 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 😿 No "natural", or Completed by 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) laborer Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mabel Elizabeth Holmes <u> Jessie Lee Hammond</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charo Bell/daughter 901 Booth St., Apt F, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, Date Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Snow Hill Del. Ctr Cem 05/12/2012 Snow Hill, Maryland 21/ Sign ture of Fugeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road - Salis., MD 21801 JOLLEY MEMORIAL CHAEPL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events CANCER COLON Due to (or as a consequence of) resulting in death) Last Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Month Year 4 Pregnant 9 Unknown Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tyes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certified completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examine?? 1 🖸 Yes 2 🗌 No. Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Tes 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babulal Das # 504B. Salisbury, MD 21804

2Th

Registrar DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

106 Milford ST.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	ryland /		artment of F rtificate of			giene Reg. No.	2012	17220
ı	Physici	an	Decedent's Name (First, Middle, Las						2. Date of De Month	Day		3. Time of Death
y'à	/Medic Examir		Frank Emory Go 4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Death	04	3 0 4c.	2012 County of Death	7:44 p <sup>M</sup>
	Funeral Director		Coastal Hospic 5. Social Security Number 218-48-8673 6. Security Number		(In yrs. last		Salish If Under 1 Year Months Days	oury	8. Date of Bir (Month, Da 2 - 22 -	th	comico  9. Birth Cou  MD	place (State or Foreign ntry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
	Maryl -f aho	tor	DE Sussex		Laur	el						1 ☐ Yes 2√☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	s 23s		34281 Columbia				19956			USA		
920	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or itams 23a or 28e-f ahow avent, tre Medical Examinar must be mutified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ Xh If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cuba 1 ☐ Yes 2 💆 No	lispanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ameri Black, White, SpecBylacl	etc.
Maryland 21215-0036	in 72 h	Completed	15. Decedent's Edi (Specify only highest grad	de completed)		(Giva	dent's Usual Occup kind of work done DO NOT use retired	during most of war	king	16b. Kir	nd of Business/Ir	ndustry
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and	2 should be filed v and Mental Hygie 'is marked other t reumatic avent, In	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam			,	
2	d 2 should th and Men ?7 is marke treumatic	၉	Clifton J. Gore	dy, Sr. <sup>Type, Print)</sup> Droti	hor 1	9b. Mailir	ng Address (Street	Virgie and Number or Ru	Lee Bo	orde: er. City or	r Town. State. Zi	<sup>o Code)</sup> 21043
χ,	1 and 2. Health ar Ism 27 is		Clifton J. Gor		11e1 5	300	Duntead	chin Dr	Ellic	ott	City,	21043 MD
Baltimore,	permit. Pages 1 and Department of Health Important: if itsm 27 any injury or other to	li i	20a. Method of Disposition 1 Burial 2 Cremation 3 1	Removal from State	20b. Place ceme	of Dispo	sition (Name of matory or other bia	aC	Date		cation - City or T	
Him	artmen ortant: injury		4 □ Donation 5 □ Other (Specify, 21. Signature of Fueral Service License		Dire			on, $ 5/5/5 $				
Ba	Deg Land		Duyella	Loke		B€	ennie Si meral F	iith Tome Sal	w. 15 .isbury	oabe.	D 21801	
*	Physician		23a. Part1. Entel the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	dications that caused one cause on each lin	Θ.	o not ent	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
F	/Medical Examiner		resulting in death)	Due to (or as a	consequence	ce of):	ic					
	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	ce of):						
68/60,	ificate be executed physicien and is the burial-transit	ai Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequenc	ce of):						
_		Medicai	IE ECNAL C.	<u> </u>								
P.O. Box	law requires that the death certifi as been signed by the attending r.2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 1 4□Pregnant at 9□Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)	,		2	23d. Date of deliv Month	ery Day Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions co	entributing to death bu	t not resulting	g in the u	nderlying cause giv	en in Part I.	23e. Did t			he cause of death?
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	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea	7.0		0	LLASOLS
sion of	ing Afte	-	27. Manner of Death  Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injur (Month, Day	y 28t	Outpatien  Time of Injury	28c. Injur Wor	4 🗆 Nursing 🗖	ome 5 Resi 28d. Describe			W) HOSPICA
DIVISION	To the Hospital or Attendi within 24 hours efter death To the Funeral Director: / completely filled in by the t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	. (Specify)				City or To	wn, State)		al Route Number,
	he Hosp n 24 hot he Fune stetely fit	edicai	29a. Certifier Certifying Phy (Check only one)	vsician: To the best of iner: On the basis of and manner stat	examination : ted.	and/or inv	estigation, in my o	pinion, death occu	rred at the time,	date and	and manner as s place, and due t	stated. o the cause(s)
	To t To tl	ž	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
		ì	30. Name and address of person who co	omploted sever of t	onth (last Oc	a) (%:::	De D	00309	0	0	4/30/1	
_	456		EHWAW WAS	my P.	ath (Item 23a	a) (Type,	1733	SALBBU	Ry u	0	2/8	2
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Fegistra	r's Signature	4	29c. Licens D Print) 1733					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9: 41 AM eanne Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Min (Month, Day, Year) Director 1 □ M 2 🗷 F 92 New York Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 28a-f 1 Yes 2 No 21 1)orceste 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? must be items 23a 50 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces Black, White, etc. ö 1 XNever Married 2 Married Completed by 2 💢 No Yes 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Amer. Tel and Tel. Co. other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မ Amy Slater John Hochreiter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Barbara J. Moir Niece 2061 River West Dr., Windsor, CO, 80550 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State emetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory 05-07-2012 | Salisbury, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Holloway Funeral Home 21. Signature of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD, 21804 K 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Approximate Immediate Cause (Final Onset and Death Physician/ MOUNASCUMM disease or condition THERESCIPLUTIC Medical resulting in death) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events MPERTENBUM and Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed death? 2 🗌 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Certificate: To 1 Inpatient 2 RR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending injury work? 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state Signature and title of certifier 29d. Date signed (Month, Day, Year) 310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21811 10324

Registrar DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-201

State

Registrar

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Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4:52 AM **Physician** /Medical Facility Name (If not institution, give street and number) tance 4b, City, Town, or Location of Death **Examiner** LIVING al Security Number 7. Age (In last birthday, **Funeral** Days Months Hours Min. Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10b. County City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the involved Examinar must be not filled at 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Modes Examinar reserved. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2No Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, awalkin Ro 20a. Method of Disposition 1 N Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location 3 Removal from State Donation 5 ☐ Other (Specify) 21. Signiture of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an certificate has autopsy performed?

1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No kanlı 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Florence Horn May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
WiCOMiCO 4b. City, Town, or Location of Death Examiner Salisbury 801 College Lane 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) 201-14-4455 Director 1 □ M 2 🛛 F 95 Yrs 09/24/1916 Pennsylvania 27 is marked other than "neturel", or Items 23e or 28e-1 show treumetic event, the Medical Examinat must be notified at 10b. County 10c. City, Town or Location filed within 72 hours efter death with the Marylend 10a, State 10d. Inside City Limits Director 1 Tes 2 X No Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21804 USA 801 College Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Housewife nd Mental Hygier marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be fill of Heelth and Mental Item 27 is marked Samuel Rubin Sarah (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6347 Olive Dr., Salisbury, MD 21801 Margie S. Evans (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1 of be bepertment of be importent: If it any injury or of once. 1 Burial 2 K Cremation 3 Removal from State Salisbury, MD Salisbury Crematory 5/7/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ ASCUD Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospitel or Attending Physicien: The law requires that the death certificate be executed hin 24 hours after death. signed by the ettending physiclen end d be deteched for use es the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 💆 Probably 4 ☐ Unknown Completed Diabates should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has b director, page 2 s performed 2 No 1 Yes director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 🕅 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funerel Director: A
completely filled in by the f Accident Investigation ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/7/12 De045995 a. Cus 170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANE A. TALK, MO 1665 wood broke Dr. Salisbury, Mr 21804 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

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	Funeral Director		5. Social Security Num N/A		ex 7. A	Age (In yrs.	last birthday, Yrs.	) If Und Months	Days	If Under Hours	24 Hrs. 8 Min.	. Date of Birt (Month, Da	y, Year)		Countr		oreign
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036	dea r ite	by	11. Marital Status  1 Never Married 3 Widowed 4		12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates.	t Everin U.	.5.			Specify:	, Puerto Ric	y Yes or No- can, etc.)	- 1		- America , White, e .ack		
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altimore, Maryland 21215-0036	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Dispos 1 🂢 Burial 2 🗆 4 🗖 D <u>ona</u> tion 5	Cremation 3	Removal from Sta		Place of Disp cemetery, cr ring				Dat				City or Tov	vn, State	
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242	tificate ng phy e as the	Med	IF FEMALE:		104.												
Box 6	Hospital or Attending Physician: The law requires that the death certificate 14 hours after death. Funeral Director: After this certificate has been signed by the attending phystely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medical	23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?	23c. If yes, outcom 1  Live Birtl 4  Pregnan 9  Unknow	h 2 ☐ Fet tat time of	tal death 3	☐ Ectopie		су			:	23d. Date Mon	of delive th	ry Day Yea	ar 
Division of Vital Records, P.O	uires that the signed by aid be deta	ed by Pł	Part II. Other significa	ant conditions o	ontributing to death	but not re	sulting in the	underlying	g cause gi	ven in Part	l.					e cause of dea ably 4 🗆 Ur	
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tal	ysician: T s certifica director, p	Bec	25. Was case referred examiner?		Hospital:					lace of Dea		nly one)				1	
f Vi	Physic r this c aral dire	2	1 Yes 2 2	No	1 ☐ Inp 28a. Date of ir	njury	ER/Outpat 28b. Time		DOA Oth	4 ∟ Nı		e 5 Residuel				hospic	<u></u>
o uo	tending Ph eath. or: After th the funeral	ficat	2 Accident	5 Pending Investigatio		Day, Year)	injury	М	work	ḱ? Yes 2□							
Divisi	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of I	njury - At h etc. <i>(</i> S <i>pecii</i>	ome, farm, s	street, facto	ory, office		28	f. Location (8 City or Tov	Street and vn, State)	d Number	or Rural	Route Number	;
	Hospi 24 hou Funer etely fil	Medical	(Check 2	Medical Exam	sician: To the best iner: On the basis o se Practitioner: To	f examination	on and/or inv	estigation, i	in my opini	on, death or	curred at th	e time, date a	and place,	, and due	to the cau	se(s) and mann	er stated.
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	Physicia	n/	Decedent's Name (First, Midd						2. Date of Dea		3. Time of Death
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	Examin	er	Western Ma		who Si	stem	Cumb	would		Alleg	
1	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9.	Birthplace (State or Foreign Country)
	Director		214-66-3401 Usual Residence of Decedent	1 □ M 2 <b>X</b> XF	57	Yrs.			May 9,	1955	MD
	land show dat	tor	10a. State 10b. Count		10c. City, T	own or Loca	ation				10d. Inside City Limits
	e Mary 28a-1 notifie	Director		mpshire	Lev	els	10f. Zip Code		т	10g. Citizen of What	1 Yes 2XXNo
	vith the	ral	10e. Street and Number 88 <b>High Mt.</b> F	?d .			25431			USA	t Country?
	leath v	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	14. Race - A	American Indian, Vhite, etc.
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	1 Never Married 2 Ma 3 Widowed 4 Divorce	arried 1 Yes 2 X			☐ Yes 2 🙀 No		, , , , , ,	Specify:	White
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421	ed with Hygier other i	l oo h	17. Father's Name (First, Middle,			Re	gistered		ne (First, Middle,	Nursing Maiden Surname)	
lan	l be fill fental rked c	오	Carroll J. Sr						ia E. Bi		
Maryland	should be filed within and Mental Hygiene. is marked other tha raumatic event, the In		19a. Informant's Name/Relation							r, City or Town, State	
	and 2 Health em 27 ther t		Susan Gallion  20a. Method of Disposition	(siste	<del>_</del>		Alameda ition (Name of	Parkway !	Date	1, MD 2101	
mor	age 1 ent of nt: If it		1 Burial 2 X Crematio 4 Donation 5 Other		e cem	etery, crema	FH PA		5-12	Cresapto	,
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service		CC020	22.		ss of Facility mc	Kee Fune	eral Home WV 26704	
	202 0		23a. Part 1. Inter the disease, shock, or heart failure. List	Approximate							
4	Ph <sub>sician/</sub>		shock, or heart failure. List Immediate Cause (Final disease or condition	Interval Between Onset and Death							
g	Medical Examiner	П	resulting in death)		in consequen		eisis				unhuown
	Lxamiller	ē	Sequentially list conditions,	b. — Due to (or as	a consequen	ce of):					Chunow M
-	uted d ansit	Examiner	if any, leading to immediate cause. E. Her G. Jerry, Ig Cause (Disease or injury that initiated events								
	cate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequen	ce of):					
092	cate be physic s the b	edic		d							
89	eath certifica attending ph for use as t	Jun /M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnance	CV.		23d. Date o	of delivery
Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transition.	Physician/Medical	in the past 12 months? 1 □ Yes 2 █ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of dea		Other (specify)			Month	Day Year
P.O.	requires that the des been signed by the s should be detached		Part II. Other significant condi	tions contributing to death	but not result	in <b>g</b> in the un	derlying cause gi	ven in Part I.	23e. Did te	obacco use contribu	te to the cause of death?
	quires t	q pa							1 🗆	Yes 2 No 3	Probably 4 Unknown
cor	law rec	Completed by							24a. Was auto	psy prior	e autopsy findings available r to completion of cause of
Re	sician: The law is certificate has t		25. Was case referred to medical	al .			00 D		1 Yes	2 No 1	Yes 2 No
Vita	ysiciar s certif directo	To Be	examiner?	Hospital: 1 ☐ Inpa	tient 2 <b>X</b> EF	R/Outpatient	Oth	lace of Death (Che er: 4  Nursing F		dence 6 🗌 Other (S	Specify)
of	ng Phys fter this ineral di		27. Manner of Death	28a. Date of inj	jury 28	Bb. Time of injury	28c. Injur wor	κ?	28d. Describe h	now injury occurred	
sion	Attending Physician: The la ser death. ector: After this certificate he by the funeral director, page	Certificate:	2 Accident Invest 3 Suicide 6 Coul	stigation Id not be	iury - At home	a farm stree	M 1et, factory, office	Yes 2 No	28f Location (5	Street and Number o	r Rural Route Number,
Division of Vital Records,	tal or A s after al Direct ed in b		4 ∐ Homicide dete		tc. (Specify)	0, 14,11, 01,01	ot, 120to. y, 011100		City or Tov		
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral process.	Medical	(Check 2 Medica	ng Physician: To the best of I Examiner: On the basis of ng Nurse Practitioner: To t	examination a	nd/or investig	gation, in my opini	on, death occurred	at the time, date a	and place, and due to	the cause(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 ☐ Certifyii 29b. Signature and title of certif		and best of filly	iniowicuge, (	29c. Licens	e number		29d. Date signed (M	fonth, Day, Year)
			1/20				DOC	60275 neach		5/24/2	2012
H	V		30. Name and address of perso		death (Item 2)	3a) (Type S	it Ha	neach	us	21750	)
	Sta	te	31. Date filed (Month, Day, Year)	32. P dist	rar's Signatur	1 1	0.11	-			

12-03301 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 17227 William H. Jones, Jr. 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) 3 Time of Death Month Day April 28, 2012 1250 hrs **Medical Examiner** Jones , William Herman 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Atlantic General Hospital Worcester 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Social Security Number **Funeral** Months Days Hours Director Country)Maryland 215-38-0524 1 X M 2 F 73 Yrs 12-31-1938 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 X No 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Willards MD Wicomico Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5229 Archie Jones Road 21874 USA Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Specify: White á 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture 8 Farmer 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Franklin</u> <u>Jones</u> Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willards, Maryland 21874 5229 Archie Jones Road, Arthur F. Jones - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State partment o 4-30-2012 Delmar, Delaware Crematory of Delmarva Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical this certificate has been signed by the attending physician a il director, page 2 should be detached for use as the burial - 1 X UNPENDED Box 68760, 23d. Date of deliver 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Records, P.O. Box The law requires that the death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 🗸 Yes ✓ Yes 2 No 2 No 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 25. Was case referred to medical Division of Vital examiner? Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 29, 2012 TE 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32, Registrar's Signature State 201 Registrar

DHMH 17 Rev 1/2001 OCMF 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month Physician/ Day 15 2012 Margaret Mae James 7:05 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mallard Bay Care Center Cambridge Dorchester Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. 2,1932 1 M 2 X F Maryland Director 217-28-4345 79 Usual Residence of Decedent or items 23a or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Bayly Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Specify: 3 Widowed 4 Divorced "natural" Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) inspector electronics 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Elmiger Tressie Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl L. Brown daughter 3220 Ocean Gateway, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 5/18/12 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ Dulmon dry disease or condition UENS Medical resulting in death) Due to (or as a consequence of) Examiner 6 month pulmonait Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month ed by the a detached f g Unknown 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ≥ Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b autopsy performed' To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🕅 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending 1 📉 Natural 1 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

atric

31. Date filed (Month, Day, Year)

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lonuson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ May 20°12 11:25a M Shirley Slacum James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mallard Bay Care Center Dorchester Cambridge 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 8. Date of Birth 6. Sex Funeral 1 🗆 M 2 🗶 F Months Days Hours Oct. 12,1945 Mary land 213-44-2373 66 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Id be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f sho **Funeral Director** 1 X Yes 2 No MD Worcester Berlin 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 13 Dockside Drive 21811 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 houn. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) clerk supermarket Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katharine Ozarski Darius H. Slacum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Dockside Drive, Berlin, MD 21811 William L. James husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 5/16/12 Hurlock, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final week Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner bral Sequentially list conditions Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsv performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 2 No ၉ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 🗀 Accident Investigation the 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and 7tle of certifier HO059973 ddress of person who completed cause of death (Item 23a) (Type, Print) Type, Print) Bramble hnson (Month, Day, Year) HAY 16 2

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 2020 PM Ernest Jefferson White Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death . REGIONAL AICOMICO MENCAL SALISBURY CENTER If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min. 1 🗓 M 2 🗆 F Director 221-09-8212 97 4-1-1915 Delaware ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Wicomico MD Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 1110 Healthway Drive, Suite 109 USA Light 2 hours after death value of the death value 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 X Yes 2 \( \square\) No 1943-Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced 1946 Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Manager 0il Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jefferson E11a Clifton Wallace White Nora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacalyn Ford - Personal Rep. 1008 Lantern Hill Court, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Milford Community Cem: 5-15-2012 Milford, Delaware 21. Signature of Funeral Service Licer 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one duse on each line. Onset and Death Immediate Cause (Final Phonocian/ monary disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) death certificate be executed Due to (or as a consequence of) resulting in death) Last ttending physician or use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No the 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2.8 autopsy performed? Yes 2 X No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 K No Other: ျ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

IVA

29a. Certifier

29b. Signature and title of certifier 1 Ston

106 Milford ST. # 504 B. Salisbury, MD 21804 Das 31. Date filed (Month, Day, Year) Registrar's Signat MAY 14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Registrar

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

057952

05/10/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Jacqueline M. Jewells 2:57 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lee's Almost Home West Ocean City Worcester Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 202**–**24–7146 (Month, Day, Year) Director 1 🗆 M 2 🖺 F 79 09/19/1932 item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Worcester West Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10117 Keyser Point Road 21842 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert Welsh Catherine Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11954 East Yardarm Dr. Berlin, MD 21811
20b. Place of Disposition (Name & emetery Date 20c. Location - City or David R. Jewells - Son 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 14 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <del>Vs</del>terans Memorial 5/16/2012 | Bear, DE 21. Signature of funeral 5 22. Name and Address of Facility 16961 Kings Hwy., Lewes, DE 19958 Parsell Funeral Homes & Crematorium Part 1. Enter the eashock, Thea failur as, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Fi disease or adition resulting in d Physician erwoute Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events signed by the attending physician and defected for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? 2 🗆 No 1 🗌 Yes 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 I Nursing Home 5 I Residence 6 DOther (Specify) (ISSING LIVENS 1 ☐ Yes 2 XXXVo မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending eral Director: A filled in by the fo ☐ Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the only one Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 H44828 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berlin MD Site 403 Rider 314 Franklin 2000 K 31. Date filed (Month, Day, 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Year Month 3 Ricky James Johnson Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONOL KICOMICO SAVISBUNU Year If Under 24 Hrs **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth 217-44-2114 Months Days (Month, Day, Year) Director 1 🗶 M 2 🗆 F 65 04/02/1947 Maryland Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 217 Glen Ave. 21804 USA 11 Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 Divorced Specify. White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) n and Mental Hygien ris marked other th Finance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Johnson Florence Shockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 306 N. Kaywood Dr., Salisbury, MD 21804 of Health a Jeremy J. Johnson/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 5/7/2012 Salisbury, MD 21. Signature of Funeral Solvice Licensee 2 Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final ONGIESTIVE HEART Onset and Death FAILURE Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine any, reading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year s been signed by the should be detach P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗌 No Yes 2 1 T Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death s after death. 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural injury Accident Suicide Investigation Could not be 1 Yes 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Name and address of person who completed dayse of death (Item 23a) (Type, Print) CARROLL ST. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarWchd-amended #20c-te-05/11/1&ertificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 955 PM Edward Waples Johnson Medical 2012 m04 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death REGIONAL AICOMICO MADICAL YONINSULA 544156410 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours Min. Year) 222-18-6343 80 **Director** 1 🛛 M 2 🗆 F 08/03/1932 Delaware Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director DE 1 Yes 2 XNo Sussex Georgetown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22729 East Trap Pond Road 19947 U.S.A. 12. Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was becedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates.1952-56 Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Pipefitter Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry J. Johnson, Sr. Emma Marker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth S. Johnson / Wife 22729 East Trap Pond Road, Georgetown, DE 19947 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 Space Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) DE Veterans Mem. Cem. Millsvoro, MD 05/10/2012 21. Signature of Funeral Service Licer Parsell Funeral Homes & Crematorium 307 N. Bedford Street, Georgetown, DE 19947 201 a. Part 1. Enter ti se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. shock, or heart fall Immediate Cause (Final Interval Between Onset and Death **Physician** disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine burial-transi and Due to (or as a consequence of) the attending physician thed for use as the buris Physician/Medical g Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) or Attending Physician: The law requires that the death in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes detached g Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by should be Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 05/09/2012 C1-0001519 TC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Bhaskar 李生 Palekar, M.D., 1526 Savannah Road, Lewes, DE 31. Date filed (Month, Day, Year,

2012

Registrar

19958

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	iryland		artment of H <i>rtificate of E</i>			Jiene leg. No. 2	012	17234
	Physicia		1. Decedent's Name (First, Middle, La.						2. Date of Dea Month MAY		20 <sup>°</sup> 12	3. Time of Death
	/Medic			ENSEN			41. O't. T	Leating of Dogsto			nty of Death	5:23 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, giv Chester River M				4b. City, Town, or Chester			Ker		
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	ı V. Year)	9. Birthp	place (State or Foreign
	Director		490-20-9505	□ M 2 <b>X</b> F	89	Yrs.	Months Days	riours Will.	July 11	1922		souri
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation				1	0d. Inside City Limits
	Maryl f sho	tor	MD Kent		Ches	sterto	own					1⊠Yes 2□No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	ntry?
	th with	a D	121 Conley Dr.				21620			U.S.		
	tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of His If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	can Indian, etc.
36	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, I've Medical Eventine I'mast be incitified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 <b>X</b> N If Yes, Give Year or Dates:	10		1 □Yes 2X No	Specify:		Spe	ecify: W	hite
5-0036	2 hou		15. Decedent's Ed	lucation	1	16a. Dece	dent's Usual Occupa	ation	de la constant	16b. Kind o	f Business/In	dustry
21		Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done d DO NOT use retired,	uring most or work )	any	~	IIama	
21	filed withi Hygiene. other thar	Con	11			Home	maker	18. Mother's Nam	e (First Middle		Home	
Maryland	thould be filed and Mental Hygi marked other imatic event, I	Be	17. Father's Name (First, Middle, Last) Allen William Ne						oher Roa		name)	
Ž	should be filed within and Mental Hygiene. s marked other than " umatic event, no "No	유	19a, Informant's Name/Relationship			19b. Mailir	ng Address (Street a				wn, State, Zij	o Code)
	d 2 th 9 th 9 tra		Beverly Churchil	**			104 Flywa		Chestert			
altimore,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition	1D	20b. Plac	ce of Dispo	osition (Name of matory or other place	e)	Date	20c. Locati	on - City or To	own, State
Ĕ	Pages ment of ant: If its ury or o		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Kent		mation Se				na, DE	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fuheral Service Lice		- м0051(		2. Name and Addres alena Fun 18 West C	eral Homorous St.	e of Ste Galena,	ephen 1 MD.	L. Scha 21635	aech
	- 2001		23a. Part 1 Per the disease, or comshock, or he It failure. List only	plications that caused	the death.		The Continues of the Co					Approximate Interval Between
	Physician		Immediate Caus - (Final disease or on hon resulting in d. th)	1.0	1.00	ry fo	silare					Onset and Death
	/Medical Examiner		resulting in death)	Due to lor as	a conseque	nce oil:	ngDisea		100	*		
	LAGIIIIIei	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Restr	rictive	e Lu	ingDisea	Se AND	C.D.P.	D		
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due 10 (01 d3	a conseque	1100 017.						
Ċ,	execu in and ial-tra	Exal	that initiated events resulting in death) Last	C. Due to (or as	a conseque	nce of):						
58760,	ficate be executed physician and s the burial-transit	edical		d				-				
_	ertifica ing ph e as th	Med	IF FEMALE:									
Вох	Physician: The law requires that the death certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal d	leath 3	☐ Ectopic pregnancy	У		23d	. Date of delive Month	very Day Year
o.	the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time or dea	atri 5 L	Other (specify)					
σ.	w requires that the d been signed by the should be detached		Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the u	inderlying cause give	en in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
rds	quires in sign	d b	Covourny Autor	y Disease	3.5H	TNI	DMTyp	2	1 🗆 🗅	Yes 2₹1	lo 3□ Pro	bably 4 Unknown
Records,	aw rec	Completed by							24a. Was		4b. Were aut	opsy findings available ompletion of cause of
	: The law cate has page 2:	)om							perfo	rmed? 2 ☑ No	death? 1 □ Yes	•
/ita	sician: The certificate irector, pag	Be (	25. Was case referred to medical examiner?	113-1			Loui	26. Place of Dea	th (Check only o	nne)		
<u></u>	Physic this c	.0	1 Yes 2 No	Hospital: 1 Inpatie		R/Outpatie	nt 3 DOA Othe	4 25 Nursing F	ome 5 Resi			ify)
Division of Vital	ding Ph h. After th funeral	tion	27. Manner of Death  14€ Natural 5 ☐ Pending  2 ☐ Accident investigation	(Month, Da	y, Year)	Injury	Worl	yat <br Yes 2□No	200. Describe	now injury o	curred	
isi.	Atten deat ctor:	fica	3 Suicide 6 Could not b	e 28e. Place of Inj	ury - At họm	ne, farm, st	reet, factory, office		28f. Location (	Street and N	lumber or Ru	ral Route Number,
á	al or safter	Certification: T	4 ☐ Homicide	building, et	c. (Specify)				City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier Certifying P (Check only one)	hysician: To the best miner: On the basis o and manner st	of examination	ledge, deat on and/or in	th occurred at the tin nvestigation, in my c	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cause(s)
	To the To the complete the comp	Me	29b. Signature and title of certifier	. /			29c. Licens	e number		29d. Date s	igned (Month	, Day, Year)
			> KAPTA	25			Doos	50996		5/2:	2/2017	Toward
	21		30. Name and address of person who									
	OI V		Neil Staddard,		Brown	n St.	Chester	town, MD	21620			
	Sta Registi		31. Date filed (Month, Day, Year)	2012	ar s bigriatu	B. 1	parkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elizabeth Kambarn Elaine 205 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dalisburg Peninsula Regimal Medical DICOMICO 8. Date of Birth (Month, Day, Year) **Funeral** If Unde If Under 24 Hrs. 9. Birthplace (State or Foreign Months 214-30-8563 **Director** 1 M 2X F 82 08/13/1929 Maryland Usual Residence of Decede 28a-f show the Maryland 10a State 10h County 10c. City, Town or Location notified at 10d. Inside City Limits Director Wicomico Salisbury Maryland 1 Tyes 2 No 10e. Street and Number 10f. Zip Code **21801** ö 10g. Citizen of What Country? ,s 23a o. must b Funeral Riverside Drive Extd. items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐ Yes 2 🛛 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify 3 X Widowed 4 □ Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pauline Zimmerman Kraus Sr. Louis Henry 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 5161 Duck Crossing Lane, Salisbury, MD 21801 19a. Informant's Name/Relationship (Type, Print) Steven A. Kambarn/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Wicomic Memorial
Park 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/12/2012 Salisbury, MD 21. Signature of Funeral Septice Lipenses 22. Name and Address of Facility Holloway Funeral Home Professional Association Rd., Salisbury, MD 21804 Snow Hill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner oira Secuentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Atria burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending holy with a stranding halferthis certificate. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Month Year Pregnant at time of death 1 Yes 2 g P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? filled in by the funeral director, Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at injury 1 Natural 5 Pending work? Accident Investigation 2 🗌 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or

Registrar

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lame and address of person who completed cause of death (Item 23a) (Type, Print)

Ohrun

31. Date filed (Month, Day, Year)

29c. License number

Carroll

29d. Date signed (Month, Day, Year, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 10 LORRAINE E. LANCIOTTI 2012 8:30 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 521 SOUTH WASHINGTON STREET EASTON TALBOT Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 216-20-8948 **Director** 1 M 2 XF 83 MAY 26, 1928 MARYLAND Usual Residence of Decedent or 28a-f shov notified at 10b. County the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director DE SUSSEX REHOBETH 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code items 23a or ner must be n 10g, Citizen of What Country? Funeral 215 LAKE DRIVE 19971 USA filed within 72 hours after death 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten 14. Race - American Indian Armed Forces? δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than ' College (1-4 or 5+) Elementary/Secondary (0-12) SALESPERSON RETAIL STORE Be oth 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) h and Mental I and, of Health and tem 27 is marn, traumatic en မ Page 1 and 2 should be EDWARD JOHNSON ANNA MAISCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE E. BIRELY, DAUGHTER 215 LAKE DRIVE, REHOBETH, DE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 5/12/2012 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 SOUTH HARRISON STREET, EASTON, MD HOME, PA 21601 MHOL R MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ementi CY disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as the IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Month 5 Other (specify) Year Pregnant at time of death Day 9 Unknown 9 Unknown P.O. signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 KNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \sum Yes 2 \sum No 5 Pending injury Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TLS

State Registrar

AKSHMI 31. Date filed (Month, Day, Year)

MAY 1 5 2012

29b. Signature and title of certifier

YAIDYANATHAN 2195 WASHINGTONST, CASTON MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

29d. Date signed (Month. Day, Year)

		Please Type or P					_		_	
		State of N	/laryland		rtment of h		Mental Hy	/gien	2012	2 1723
		Registrar  1. Decedent's Name (First, Middle, Last)			ificate of L		2. Date of D	Reg. N	0.	O Tive of Beeth
Physicia Medic		Jessica		Lit	Hetor	1	Month		2012	3. Time of Death 0/40 M
Examin	er	4a. Facility Name (if not institution, give street and nymber, The Johns Hopkins Hosp	ital		Battin		ty	4	c. County of Deat	h 
Funeral Director		5. Social Security Number  216–15–6349  Usual Residence of Decedent	Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D 05/27/	ay, Year)	Cor	thplace (State or Foreign untry) <b>ryland</b>
and show	ř	10a. State 10b. County	10c. City, T	Town or Loca	ation	<u> </u>				10d. Inside City Limits
Maryl 28a-f otifiec	Director	Maryland Wicomico	Ma	rdela	Springs					1 ☐ Yes 2 <b>X</b> No
ith the 23a or st be n	ralD	10e. Street and Number  10045 Wallertown Road			10f. Zip Code 2183'	7		10g. C	itizen of What Co USA	untry?
ems arr mus	Funeral	11. Marital Status 12. Was Deceden		13. W	as Decedent of H	ispanic Origin? (S	pecify Yes or No	-	14. Race - Ame	rican Indian,
permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Hygiene.  Department of Health and Hygiene.  Department of Health and Hygiene.  Department of Health and Health and Hygiene.  Department of Health and Hygiene.  Department of Health And Hygiene.  Department of Health And Hygiene.  Department of Health And Hygiene.  Department of Health And Hygiene.  Department of Health And Hygiene.  Department of Health And Hygiene.  Department of Health And Hygiene.  Department of Health Hygiene.  Department of Health And Hygiene.  Depar	by	1   Never Married 2   Married	lf.	Yes, specify Cuba  ☐ Yes 2 🛣 No	ın, Mexican, Puer	to Rican, etc.)		Black, White Specify: Whi	e, etc.	
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d be filed Mental H arked ot atic ever	To Be	17. Father's Name (First, Middle, Last) Ralph McKinley Littleton					me (First, Middle y Louise			
id 2 shoul		19a. Informant's Name/Relationship (Type, Print)  Kathy L. Littleton/Mother		19b. Mailing 1004	Address (Street and 15 Walle)	and Number or Ru rtown Rd	ral Route Numb •, Marde	er, City d e <b>la</b>	r Town, State, Zip S <b>prings,</b>	MD21837
t of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from Sta		ce of Disposi netery, crema	ition (Name of atory or other plac	ce)	Date		ocation - City or	
iit. Pag artmen ortant: injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	Sali		Cremato		.2/2012	_	lisbury	
Deps Impo		David H. Rompon	- CFS	#1 50   90	olloway Ol Snow	Funeral Hill Rd.	Home Pro , Salish	ofes: oury	sional A , MD 218	ssociation 04
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Medical Examiner		Due to (or a	s a consequen	nce of):						
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iding p	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	e of pregnanc	:y					23d. Date of del	livon
to the hostilate or Attending Prysician: The law requires that the death certificate be ex- within 24 hours affect cleath.  To the Funeral Director: Affer this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medica	in the past 12 months?	n 2 🗌 Fetal d at time of dea	leath 3 🗌	Ectopic pregnand Other (specify)	cy			Month	Day Year
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Ine lav ate has page 2	Completed							opsy formed? 2	death?	completion of cause of
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withi To th	_	29b. Signature and title of certifier			29c. License	e number		29d. D	ate signed (Month	n, Day, Year)
STA.		30. Name and address of person who completed cause of	dogth /ltan 01	2n) (Time D	KES	- 000		IV(A	+7 8"=	2012
		ATUL KALANURIA		oa) (Type, Pr	29c. License RES int) POD N· Ú	rleans S	+ Balt	MOI	e MD I	1287
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DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month 2012ª Bernard Lee Loar 14 1318 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 752 Dogwood Ct. Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Hours Nov 26, 1946 **Director** 1 🕅 M 2 🗆 F 215-44**-**8909 65 ms 23a or 28a-f show must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 USA 752 Dogwood Court ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 XYes 2 Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Vietnam white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Kelly Springfield Tire Co. 6 <u>Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lora May Sturtz t. Page 1 and 2 should be trment of Health and Mer trant: If item 27 is mark Bernard Loar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1001 Carroll Parkway Apt. 207 Frederick MD 21701 Joan Loar wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Temation 3 Removal from State 4 Docation 5 Other Specify) 5/18/2012 Scarpelli Funeral Home, P.A. Cresaptown MD 22. Name and Address of Eacility
Scarpelli Funeral Home, PA of Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Dennentia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to or as a consequence of): that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) trederick, MD 21702 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Box 68760

P.O.

		1	For State	State of Maryl		rtificate of D			Reg. No.			,
			Registrar  1. Decedent's Name (First, Middle, La	est)		timouto or z		2. Date of Dea	th	Voer	3. Time of	Death
	Physician Medic	al L	Mary	Priscilla	Llewell	yn		May	19, 201		2335	М
	Examine		4a. Facility Name (if not institution, giv			4b. City, Town, or Frostb	Location of Death		4c. Count	gany		
	Funeral		Frostburg Villag 5. Social Security Number 6.3	Sex 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		place (State o	or Foreign
	Director		7 13-70-7413	1 D M 2 DF 91	Yrs.	Months Days	Hours Min.	Jan 3,	1922	·	MD	
_	nd how	2	Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	ocation				1	0d. Inside Ci	ity Limits
	Maryla 18a-f s	rect	MD Alleg	gany	Ra	wlings						2 🗆 No
	h the last or 2	by Funeral Director	10e. Street and Number			10f. Zip Code	21557		10g. Citizen of	What Cour	itry?	
	ath wit	nner	15429 Hawk St	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		cify Yes or No-	14. Ra	ce - Americ	an Indian,	
2	be filed within 72 hours after death with the Maryland ental Hygiene. Yead other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.		If Yes, specify Cuba 1 ☐ Yes 2 🔻 No		Rican, etc.)	Specif	ock, White,	<sub>etc.</sub> hite	
5	"hours "natur dical I	Completed	15. Decedent's (Specify only highest of	Education	(Give	dent's Usual Occup		ing	16b. Kind of I	Business In	dustry	
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d	ould be filed within 73 dd Mental Hygiene. marked other than matic event, the Me	욘	Willam Loar					mona Po				
Mai	short han 7 is trau		19a. Informant's Name/Relationship Linda Gordon	(Type, Print) niece	19b. Mail <b>3</b> 2	ing Address (Street a 2 Watercli	and Number or Rura ff Street	al Route Number Lor	r, City or Town, naconin(	State, Zip	MD 21	539
more,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State	Ob. Place of Disp cemetery, cre Sunset Me	osition (Name of ematory or other place emorial Park	ce)	Date 5/24/2012	20c. Location	n - City or To nberla		MD
Baitimor	permit. Departn Imports any inju		21. Synature of Funeral Serviol Lice	nsee	2	2. Name and Addre Scarp	ssof Eacility elli Funeral H irginia Avenu	ome, PA	land. MD 2	21502		
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F	h, ician/		Immediate Cause (Final disease or condition	CEREBR	O VASO	CULAR	ACCIDE	NI			Onset and	
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3	certificate be executed nding physician and use as the burial-transit	ledical		d								
χ ×	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnan	су			Date of deli	very	Year
POX	the at	ysic	1 Yes 2 No	4 Pregnant at tim	e of death 5	Other (specify)						
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VII 3	Physician: The law this certificate has al director, page 2 a	To Be	examiner? 1  Yes 2 No	Hospital:	2 ER/Outpat	ient 3 DOA Oth	ner: 4 Nursing H	ome 5 Resi	idence 6 🗆 O	ther (Speci	fy)	
101	ing Ph		27. Manner of Death  Natural 5 Pending	28a. Date of injury (Month, Day, Ye	28b. Time injury	wor	ryat rk? ∐Yes 2 □ No	28d. Describe	how injury occi	urred		
Sion	Attend death ctor: A	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot be 28e. Place of Injury -				28f. Location (	Street and Nur	nber or Rur	al Route Nur.	mber,
DΝ	tal or / rs after al Dire ed in b		/	building, etc. (3				City or To				
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attercompleted filled in by the funeral director, page 2 should be detached for	Medical	(Chook 2 Medical Ex	Physician: To the best of my aminer: On the basis of exam Jurse Practioner: To the bes	ination and/or inv	estigation, in my opin	ion, death occurred	at the time, date	and place, and	due to the c	:ause(s) and n	nanner stated
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			> How				26907		MAY	22,	201	2
	81		30. Name and address of person with Harrit Sichu	no completed cause of death	n (Item 23a) (Type	e, Print)	RA C	imbe-	-land	TAN	\ 215	(02
1	Sta		31. Date filed (Month, Day, Year)	0010 32.F	pature	b Walsh	1 10-11 0	MINI	رما روا	1001		,
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Franklin Delano Lower April 2012 6:44P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Health Nursing and Rehab Cumberland Allegany Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1**X** M 2□ F 232-60-8149 74 **Director** Feb. 5, 1938 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV Mineral Keyser 1X Yes 2 □ No ral", or items 23a or 28a-f sl Extr. inc. in ust be rectified Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12 N. Main Street 26726 United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Extrainer rough once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 K No Specify. Specify: White þ Yes Give 3 ☐ Widowed 4 🏋 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Timber Cutter Pulpwood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Lower Laura Elizabeth Devers ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samantha Kesner/Daughter Rt. 1 Box 152K Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Thrush Cemetery 04/21/2012 Antioch, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Litters Smith Funeral Home 85 S. Main St. Keyser, WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lower Immediate Cause (Final 5 1)13 care home **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ctopic pregnancy Month Day 5 Other (specify) P.O.1 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: ANUrsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident the f 6 Could not be 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil K. Gupta 625 Kent Avenue Cumberland, MD 21502 31. Date filed (Month, Day, Year) MAY 3 1 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Junius 8 2012 9:25A Artney Miller May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Talbot Genesis HealthCare-The Pines Easton 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 🗆 F Months 03-05-1925 87 Maryland Director 220-16-9385 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Director Md. Talbot 1 Yes 2 No Easton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 406 Moton St., Apt. 304 21601 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Black, White, etc. à 1 Never Married 2 Married Junius Miller Baltimore, Maryland 21215-0036 1 ☐ Yes 2. No 3 Widowed 4 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Talbot County Elementary/Seconday (0-12) College (1-4 or 5+) Schools Public Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Miller Williams Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Miller/Wife 406 Moton St., Apt. 304, Easton, Md. 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Md. Veterans Cem. Hurlock, Maryland 05-21-12 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St., Easton, Md. 21601 21. Signature of Fur eral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ISCHEMIC disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions One to for easy nonnectioned off cause. Enter Underlying Examir that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autonsy certificate 1 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other 2 1 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Lettifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4+VA 610 Dil 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 02/0 AM Henry Merritt Ma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ma. wicomico CENTER Salis 5ALISBURY REHABOL NURS buny 8. Date of Birth (Month, Day, Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Country. Director 216-14-9905 93 1-16-1918 Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits 28a-f sho 10a State 10c. City. Town or Location the Maryland Examiner must be notified at Director 1 ☐ Yes 2 X No MD Wicomico Pittsville 10g. Citizen of What Country? 10f. Zip Code ö 10e. Street and Number Funeral items 23a should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or items 23a 34090 Rounds Road 21850 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces
1 X Yes 2
If Yes, Give
Year or Dates led Forces? 1 Yes 2 □ No 1940þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed 1943 White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Poultry 8 Chicken Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Page 1 and 2 should be 1 ment of Health and Menta Isabelle Roy Merritt Dobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other transcence. Ida A. Webb - Sister 1704 Eastgate Drive, Apt. 408, Salisbury, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva 5-7-2012 4 Donation 5 Other (Specify) Delmar, Delaware Funeral Service 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, Maryland 21804 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between One and Death 23a. Part 1. Enter the disease, or compressions, or heart failure. List only the Immediate Cause (Final Physician/ 1 a lmon Las disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Month 2 No 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yenoris 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate has performed To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the 29c. License number 29d. Date signed (Manth, Day, Year) ,VK

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Yi

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Are Salisbury

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Drodulja

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 20, 2012 Physician/ 0355 Mulvev Medical Betty 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Golden Living Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday, 8. Date of Birth **Funeral** Nov 4, 1922 Director 1 M 2 XF 217-18-4800 89 Usual Residence of Decedent 10c. City, Town or Location 28a-f shov 10d. Inside City Limits 10a. State Examiner must be notified at Director Cumberland 1 X Yes 2 No MD Allegany 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 0 items 23a Funeral USA 21502 512 Winifred Road ould be filed within 72 hours after death v Id Mental Hygiene. marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify Specify: white Completed 3 □ Widowed 4 □ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) own home <u>homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary J. Taylor Joseph W. Eady of Health and Nitem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) MD 21502 Cumberland 39 Moran Avenue **Betty Pfeiffer** niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Date cemetery, crematory or other place)

Rocky Gap Veterans Cemetery Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 5/22/2012 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Parent Home, PA of Funeral Sei ignatur icensee 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consest ence of) Examiner Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has b performed? death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation s after death. Accident
Suicide the 1 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State, 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United The Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number person who completed cause of death (Item 23a) (Type, Print) Cumberland, Md 21502 Carrington Ct, 31. Date filed (Month. Day: Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Dorothy Catherine Mullaney 9:30 PM Mav 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Lutheran Village Healthcare Westminster Carroll 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 218-16-1491 July 25, Director Maryland 1 M 2 XF 1923 88 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Carroll Westminster 1 Yes XX No 10f. Zip Code 9 10e. Street and Number 10a. Citizen of What Country? 23a 250 St. Luke Circle #601 21158 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. life. DO NOT use retired)
Homemaker Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) Anna Novotny 17. Father's Name (First, Middle, Last) should be file and Mental F is marked o John G. Hines, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 is John G. Hines, Jr./Brother P.O. Box 1102, Shepherdstown, W 25443 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith May 24, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2PrittsAFenerally Home and Chapel, P.A. 1/2/ 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the dark shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Opset and Death Physician/ disease or condition resulting in death) Medical Due to (or as **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician a Physician/Medical Division of Vital Records, P.O. Box 68760 as attending p IF FEMALE: use a 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the 9 Unknown signed by the Other significant conditions contributing to death but not esulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Funeral Director: After this estely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: I or Attending F after death. Natural 5 Pending injury work? 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determines City or Town, State) the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one

Registrar DHMH 17 Rev 06-2011

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29b. Signatur

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14<sup>Pay</sup> Month 2012<sup>Year</sup> Betty Ruf Nagel 5:35 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 7012 Hubbard Road Federalsburg Caroline 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth Funeral 1 □ M 2 🗓 F Davs Hours Jan. 27, 1932 Maryland Director 214-28-8101 80 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2🗓 No Maryland Caroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7012 Hubbard Road 21632 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 11 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John George Ruf Nora Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Nagel/Son 7012 Hubbard Road, Federalsburg, Maryland 21632 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1. Department of I Important: If it cemetery, crematory or other place) 5 1 X Burial 2 Cremation 3 Removal from State injury o 4 Donation 5 Other (Specify) Maryland Veterans Cem. 5/21/2012 Beulah, Maryland 21. Signs ture of Funeral Service Licen Name and Address of Facility eller Funeral Home, P. O. Box 207 06 Main Street, East New Market, Kencele 23al Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cancer disease or condition resulting in death) -wna Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b 24a. Was an autopsy performed After this certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: ဂ္ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Accident work? 1 ☐ Yes 2 ☐ No the Funeral Director. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0002392 MD 6106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stank RZ Preston MD 21655

Registrar

State

20

31. Date filed (Month, Day, Year)

3683

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State Amen	d Item	25 per m	Marylan e <b>, g 928</b>	d Depa 06/19/ Cer	rtment o /2012dh tificate o	f Hea <b>b</b> f Dea	alth and ath	Mental Hy	giene Reg. N	e o. 20	12	1	7246
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592	ding Phys	cate: To	27. Manner of Death	5 Pending Investigation	28a. Date of (Month)	ipatient 2  injury , <i>Day</i> , <i>Year</i> )	28b. Time of injury	28c. I	njury at vork?	☐ Nursing ☐ 2 ☐ No	Home 5 ☐ Resi 28d. Describe I			Specify)		
Lund	I or Attend after death Director: A	Certificate:		6 Could not be determined	e 28e. Place o	f Injury - At ho , etc. <i>(Specify</i>	nme, farm, stre	et, factory, offi	ce		28f. Location ( City or Tox			or Rural F	Route Nu	mber,
3	Division to the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	(Check 2	Medical Exam	sician: To the bes iner: On the basis se Practitioner: 1	of examination	n and/or investi	igation, in my o	olnion, de	eath occurred	at the time, date a	and plac	e, and due to	the caus	se(s) and	manner stated.
ME	To the within To the company		29b. Signature and title	e of certifier	LK	1	),0	29c. Lic	ense num	283		29d. Da	ate signed (A	Month, Da	ay, Year)	
2 20	010		30. Name and address	s of person who	completed cause	of death (Item	1 23a) (Type, P	rint) /Thuly	B	rul	Berli	(2)	no	0	218	2//
et	Sta Registr		31. Date filed (Month,	Day, Year 20		gistrar's Signat	b. pa	No								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month erce Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Chester 9. Birthplace (State or Foreign Country) KIN GN If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, 1 🗷 M 2 🗆 F Months Days Hours **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits nester 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Kiversid 21619 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government 10 Th orrectiona Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pierce မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) revce Cron 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Removal from State cemetery, crematory or other place) Chester Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry avelle  $\mathcal{C}$ )ashinaten 57 Cambridge Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Physician/ 1146 CHENIC 0 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown Unknown Division of Vital Records, P.O. Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ROSTA 24a, Was an certificate has the irector, page 2 s autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural
Accider
Suicide 5 Pending w<u>ork</u> within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Tes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 00027055 Name and address of person who completed cause of death (Item 23a) (Type, Print) KERSON Medical Ctr. Rd GRASONV. 11e 204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ann ierce 11: 22 AM. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6325 Queenstown Main Queen Hnnes If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) May law Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Month, Day, Min **Director** Jan. Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director uueenstown 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21658 Main 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 2 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 KNo Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) sovernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lane arsha 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 9/2012 Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Kenelle C. Washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami I-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗌 No 2 🙀 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2. No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛚 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 5 DO6270 55 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

MD204 med

SON MD legistrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene												
			State Registrar	Ce	rtificate of Deatl		Reg. No. 2012 11243								
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)	Examin		4a. Facility Name (if not institution, give street and number)  The Johns Hepkins	tospital	4b. City, Town, or Location Baltomore	1 1	,	4c. County of Death							
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	Director		220-52-1176 Usual Residence of Decedent	62 Yrs.		FEB.	1, 19	950 MAR	YLAND						
	show dat	tor	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits						
	Mary 28a-f otifie	Director	MARYLAND WORCESTER	BERLIN					1 X Yes 2 □ No						
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36	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It marked of they than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☒ Married  1 ☐ Never Married 2 ☒ Married  1 ☒ Yes 2 ☐ If Yes, Give  2 ☐ If Yes, Give	No	If Yes, specify Cuban, Mexi  1 ☐ Yes 2 🏋 No Specific Sp		(C.)	Black, White, Specify: WH	etc. ITE						
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	and 2 s Health tem 27		LINDA W. PALMER/WIFE		HENRY'S MILL	T									
Jore	a 0 + -		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State	1	matory or other place)	Date 5 / 5 / 1 2		Location - City or T							
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9 x	the death certificat by the attending ph tached for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year						
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours affer death.  To the Funeral Director. After this certificate has been signed by the attending physician and to the Funeral Director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e	xamination and/or inve	stigation, in my opinion, deat	th occurred at the time	e, date and pla	ace, and due to the c	ause(s) and manner stated.						
	To the within To the compl	Σ	29b. Signature and title of certifier		29c. License numb	per	29d.	Date signed (Month	Day, Year)						
9	200		Inthay trattalone		KES	000		MAY 2	2012						
1	PIN				RES Polfe Street	Baltimo	re 1	UD 217	187						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 17250

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Physicia	ın/	Decedent's Name (First, Midd	lle,Last)	-				Date of Dea     Month	th Day Yea	-	ime of Death
ledical Examir		MATTHEW	LEE	PAT				April 27, 2	012		710 hrs
		4a. Facility Name (if not institution 37110 Mount Pleasa			4	<ul><li>b. City, Town, or L</li><li>Willards</li></ul>	ocation of L	Jeath	4c. County o		
		5. Social Security Number		e (In yrs. last	birthday)	If Under 1 Year	If Under 2	4Hrs. 8. Date of Bir	th (MM/DD/YYYY		ce (State or
Funeral Director		218-08-1121	1 X M 2 F	37	Yrs.	Months Days		Min.	5, 1975	Foreign	) MARYLAND
	ŀ	Usual Residence of Decedent	I A M Z F	37	115.	LL		DAN. Z	J, 19/J		TAKTLAND
any	- 1	10a. State 10b. County		10c. City, To	wn or Location	on					. Inside City Limits
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Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wh	at Country?	
th the Maryland 23a or 28a-f sho notified at once.		5560 BAKER ROA	VD			21874			USA		
h with	eral	11. Marital Status  1 Never Married 2 X N	12. Was Decedent Armed Forces?			Decedent of Hisp es, specify Cuban,		? ( Specify Yes or No uerto Rican, etc.)	- 14. Race White	- American Ir e, etc.	ndian, Black,
or deal	Funer		1 Yes 2 vorced If Yes, Give Year	X No	1	Yes 2 X No	snecify:		Specify:	WHIT	re.
rs afte	2	3 Widowed 4 Dir 15. Decedent's Education (Spe	or Dates:	npleted) 16	6a. Decedent	's Usual Occupation	on (Give kin		16b. Kind of Bus		
5-0036 led within 72 hours af tygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)			during mo	st of working life.	DO NOT us	e retired)			
215-0036 be filed within 77 ntal Hygiene. rked other than	힅	12			FARME	ER			AGRIC	ULTURE	<u> </u>
5-00 led with Hygien other		17. Father's Name (First, Middle				1		Name (First, Middle, I			
2121 uld be fil Mental F marked	Be		LEE PATEY		10h Mailing	Address (Street	JAN	ICE A. er or Rural Route Nur		TON	Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	의	19a. Informant's Name/Relation TRACY A. PAT			_			LLARDS, M			
and 2 fealth traus	ŀ	20a. Method of Disposition	LLI/ WII L		ce of Disposi	tion (Name of cem		Date	20c. Location -		ı, State
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Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: Witem 27 is n injury or other traumatic	ŀ	4 Denation 5 Other S 21. Signature of Funeral Service	specify: e Licenses		22. N	ame and Address	of Facility		L		
ii ii Dep		Trule le	Hart					HOME, SE			
Physician		23a. Part I. Enter the disease, o failure. List only one cause	or complications that caused e on each line.	the death. D	o not enter th	e mode of dying, s	such as card	diac or respiratory arr	est, shock, or hea	art Ap Be	oproximate Interval etween Onset and
⊮edical Examiner		Immediate Cause (Final disease								_	Death
		or condition resulting in death)	Due to (or as a const	equence of):							
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):							
	amine	cause. Enter Underlying Cause (Disease or injury that initiated	5 1 /	equence of):		-	Fa.			_	
uted Id ansit	Ä	events resulting in death) Last	d								
60, ate be executed obysician and burial - transi	Medical	UNPENDED	AMENDED								
760, cate be physic		IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outcome	me of pregnar	. —		7		23d. Date of	-	Year
68 certifi nding	ian	past 12 months?	I LIVE DITUI	time of death	- =	aldeath <sup>3</sup> [ ner (Specify)	Ectopic p	regnancy	Month	Day	real
Box 687( ne death certifica the attending planed for use as the	Physician/	1 Yes 2 No 9 Ur	nknown 9 Unknown		о <u> </u>						
P.O.	by P	Part II. Other significant cond	itions contributing to deat	h but not resu	ulting in the u	nderlying cause gi	iven in Part		obacco use contri		
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f Vi Physi ral dir	၉	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		R/Outpatient 8b. Time of Ir		y at Work?		how injury occur		:116
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seen is led in by the funeral director, page 2 should	<u>io</u>	1 Natural	nding FOUND: Day,	rear) F	OUND:		es 2 N	Subject pin	ned in excava	ator by fall	len tree
isio	īcat		estigation Apr 27, 2012 28e. Place of Ir		1659 hrs ne, farm, stree	et, factory, office bu	uilding, etc.			er or Rural R	toute Number, City
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Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying I	Physician: To the best of m	ny knowledge	, death occur	red at the time, da	ite and place	e, and due to the cau	se(s) and manner	r as stated.	(2)021
To the within To the compl	Medical	one) 2 Medical Ex  29b. Signature and title of certif	aminer:On the basis of exa	milliation and	uoi iiivestigat	29c. License		in ou at the time, trate	29d. Date sign		
	2	29b. Signature and title of Certif	1 // mi	>		O.C.N			April 28, 20		200, 100.
		30. Name and address of person	Minute of the state of	death (Item 2	3a)						
1510		Melissa Brassell, MD	Assistant Medica		,	. Baltimore St	treet, Bal	timore, MD 212	23		
St	ate	31. Date filed (Month, Day, Year	Registra	ar's Signature							
Regis	trar	I'AI L	2012 Sknows	J. P.	park						
DHMH 17 Rev 1/2	001				<b>ORIGINA</b>	L					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DENNIS JOHN PARISEAU Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. Social Security Numbe Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Hours 021-32-7088 Director 1x x M 2 🗆 F Yrs. 69 APR.8,1943 MASSACHUSETTS Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES WALDORF 1 Yes 2xXVo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2009 ROSEWOOD DRIVE 20601 U. S. A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. 61 IS eau, Veriff 115 171Baltimore, Maryland 21215-0036 1 Yes 2 No Specify and Mental Hygiene.

is marked other than "natural",
aumatic event, the Medical Exal Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) SERVICE STATION OWNER SERVICE STATION Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 0 ADRIEN PARISEAU EVIRA MONIZ other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any injury or other transcence. CAROLYN PARISEAU/SPOUSE 2009 ROSEWOOD DRIVE WALDORF, MARYLAND 20601 eal 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MAY Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State VETS.CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 29,2012 CHELTENHAM, MD or Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a conse that initiated events resulting in death) Last Due to (or as a consequence of physician the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Day Pregnant at time of death ed by the a g Unknown Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law thin 24 hours after death. the Funeral Director: After this certificate has: mpletely filled in by the funeral director, page 2. autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State within 24 hours a To the Funeral C Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nyrsa Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dat, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SYLVIA JOAN CASE RUSSELL MAY A.M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death CIVISTA MEDICAL CENTER LA PLATA CHARLES Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 244-44-6894 Director 1 □ M 2 🙀 F 79 JULY 4,1932 NEW YORK Usual Residence of Decedent shov 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f CHARLES 1 Yes 2X XVo MD WALDORF 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 13550 HAVENSBROOK DRIVE 20601 U. S. A. "natural", or item edical Examiner n 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify Specify: WHITE Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) COMMUNITY COLLEGE CODING CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HOLMES DEMPSTER CASE ANNE GENEVIEVE FARRELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 12795 FOREST PARK DR., WALDORF, MD 20601 JOSEPH H. RUSSELL SON other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p MAY Date 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State injury or Department Important: I any injury or once. 25,2012 METRO . CREMATORY ALEXANDRIA, VA 4 Donation 5 Other (Specify) Signa ure of Funeral Service L 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dynahock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMONIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events HCCEOFENT with 13 resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform cate Yes 2 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes ျှ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending death. eral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death only one curred at the time, date and place, and due to the cause(s) and manner as stated Signature h (Item 23a) (Tvo ALDORE, MIL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kolle er Son 8:55 A 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, 4c. County of Death 60 MICO **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 88 **Director** 1 **M** M 2 □ F Maryland 18 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗆 Yes 2 🗙 No Somers Westover Maryland 9 10g. Citizen of What Country? Funeral Cost 2187 S. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Examiner Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🐪 No Specify: Yes. Give 3 ☐ Widowed 4 ☐ Divorced Specify: Black Year or Dates Baltimore, Maryland 21215-0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than aumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade American Paving Co. Truck Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Kolle laylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Rolley 32 charlotte Rd. Costen Westover, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 21/12 Station, mo Marion 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee E. Ward Princess Anne, MD, 21853 Ave 0639 Hampden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CINDUY MAHGNANT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran the burial-trar Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy 1 Yes 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 TNo ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 4 iniury Natural 5 Pending Investigation 1 Yes 2 🗌 No Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifie 29c. License number 12005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1802 Bra 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Dorothy P. Riley 1640 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death isbur Wicomico ry Rehabilitation a Nursing Ctr If Under 1 Year If Under 24 H/s 8. Date of Birth (Month, Day, Yea 8-1-1924 Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Maryland 1 □ M 2 🖾 F Months 87 Director 199-18-4736 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 1 🛚 Yes 2 🗆 No MD Wicomico Salisbury 10e, Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 810 College Lane Apt. F 21804 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Examinar mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: white Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Reginald Pattey Dorothy Wigton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) William Curtis Riley 21804 4472 Sturbridge Drive Salisbury, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington Cemetery May 11, 2012 Drexel Hill, PA 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licensee Delmar, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between set and Death Immediate Cause (Final Physician/ ardiomy CW3 disease or condition Medical resulting in death) Due to (or as a consequenc of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. burial-transi Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 Yo been signed by the atte should be detached for Month Day Year Pregnant at time of death Unknown death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 24 hours after death.

Funeral Director: After this certificate I 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 NO ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa 29c. License numbe 29d. Date signed

State Registrar

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32.

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Edward James Ranshaw Jr. 005 A mar 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rebab AND HURS wicomico 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min 02/06/1922 216-18-2764 **Director** Maryland Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 28a-f Maryland Wicomico Quantico 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 25124 Nanticoke Road 21856 USA permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important if item 27 is marked other than "marked other than any injury or other than" 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married A ノミんのい d 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White 3 Midowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Head Custodian Board of Education Be DシタRG RA imore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Susan Revell Edward James Ranshaw Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25124 Nanticoke Rd., Quantico, MD 21856 Wayne Turner/Step-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Springhill Memory
Carcens 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/10/2012 Hebron, MD Holloway Funeral Home Professional Association 21. Signature of Funeral Service Censes 501 Snow Hill Rd., Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cers. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be used hours after death.

24 hours after death.

a Funeral Director. After this certificate has been signed by the attending physicial physicial in by the funeral director, page 2 should be detached for use as the burneled filled in by the funeral director, page 2 should be detached for use as the burneled. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu 29c. License number 29d Date signed (Mor

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day,

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VICAVE SALISBURY

who completed cause of death (Item 23a) (Type, Print) nD.

gistrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna Mary Roderick May 20, 2012 5:45 PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Homewood at Crumland Farms Frederick 5. Social Security Number 216-54-8058 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Min **Director** 1 □ M 2**X** F 97 Nov.14,1914 Maryland 28a-f show at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7407 Willow Road 21702 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. or . þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 nan "natural", Medical Exar 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) t of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucretia Michael ပ္ Noah E. Kefauver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2  $1039\,$  Central Ave., Wilmette, IL  $60091\,$ Marianne C. Roderick, daughter 20a. Method of Disposition
1 □ Burial 2 IXCremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō Department of Important: If any injury or once, Smithsburg Crematory May 22, 2012 Smithsburg, MD 4 Donation 5 Other (Specify) of Futuers I Service Liv <sup>22</sup>Klame and Address of Bastord PA Funeral Home 106 East Church St., Frederick, MD M00255 23a. Part 1. Enter the disease, or comp ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only of Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Math Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 SB IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dichetes 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law thin 24 hours after death.

the Funeral Director: After this certificate has I performe 1 🗌 Yes 2 🔲 No Yes 2 A completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 X 100 Hospital Other: 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) May 21, 2012 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) est, Fragon 4. MD 21701 <del>2</del>53

State Registrar 31. Date filed (Month: Day, Year)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SWAIM Vear Physician/ 3:42 p M LILLIAN 05 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** DORLHESTER CAMBRIDGE GENERAL HOSPITAL CDORCHESTER 8. Date of Birth

June II 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours 1 M 2 X F North Carolina 244-42-9616 Director Usual Residence of Decedent or items 23a or 28a-f shov 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Dorchester MD Cambridge 1 X Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 751 Foxtail Drive 21613 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) aide public school 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ John Saunders Jane Fachee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey S. Abbott daughter 7902 Hart Glen Ct., St. Michaels, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 5/15/12 Delmar, DE Crematory of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ULMONARY FIBROSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PULMONALE COR Sequentially list conditions Examine La y, leading to infried a cause. Enter Underlying Cause (Disease or linjury Day to be as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day Pregnant at time of death 5 Other (specify) signed by the a 1 | Yes 2 | 9 | Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 PUnknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performed? death? 2 📜 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 2 👺 No မ 1 Plnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: Natural Accident iniurv 5 Pending Investigation within 24 hours at er deatl To the Funeral Director 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69234 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ERRABOLU

STREET

BYRN

Registrar's Signa

MARYLAND

CAMBRIDGE

21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month MARY ELIZABETH 12:00 P M SUAREZ Mav 10, 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crisfield

If Under 1 Year | If Under 2 Alice Byrd Tawes Nursing Home Somerset 5. Social Security Number . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 ☐ M 2 🖫 F 92 Director 214-32**-**1644 Feb. 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Crisfield Somerset 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 26474 Asbury Avenue

Maritai Status

Avenue

12. Was Decedent Ever in U.S. Armed Forces?

Armed Forces? 21817 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, 11. Maritai Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify White þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 10 <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace Wilson Daisy Sterling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Suarez (son) 702 Highwood Drive - Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐Removal from State Sunnyridge Mem. Park 5/12/2012 Crisfield, Maryland 4 Donation 5 Dother (Specify) 21. Sign was Funeral Service Vice ee

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main St. - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) physician Physician/Medical as the attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy for Month Day Year signed by the at d be detached for 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cate has been signated to page 2 should to Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? res 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Uursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

death certificate be executed P.O. Box 68760, Division or Vital Records, Attending Physician:

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di Medical +5 HIT Registrar

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 10/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vijay Karumbunathan, M.D. - 201 Hall Highway, Crisfield, MD 21817

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SWEEP Day ETHEL S. May 2012 1:22 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5195 Debra Road Crisfield Somerset 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours 235-60-9865 Days (Month, Day, Year) 1 . M 2 X F **Director** 72 Yrs Nov. 24, 1939 West Virginia Usual Residence of Dece ? Is marked other then "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2X No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5195 Debra Road 21817 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. White 3 Widowed 4 Divorced Specify: Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 Is marked other then " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Bert Collins Afton Broom 1 and 2 should by Health and Meltern 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Sweep (Husband) 5195 Debra Road - Crisfield, MD 21817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If Ite eny injury or of 1 X Burial 2 Cremation 3 Removal from State Blue Ridge Mem. Gardens 05/16/2012 Beckley, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal west Function Service West Property Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ crhos Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician end burial-transit Exami The law requires that the death certificate be executed Cause (Disease or rigor that initiated events resulting in death) Last Due to (or as a consequence of) the attending physiciar Physician/Medicai P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No ģ Dav 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, been si 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certific funeral director, the Hospital or Attending Physician: 25. Was case re Be ed to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 - Pending injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) May 9, 2012 0137 of person who completed

State

Registrar

31. Date filed (Month, Day, Year)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2012 12, Marguerite Ε. Sherman 11:20A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gaithersburg Wilson Health Care Center Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Sept. 12, 91 1920 Pennsylvania Director 174-18-3404 Usual Residence of Decedent ems 23a or 28a-f show r must be notified at show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 Russell Avenue 20877 U.S.A. items ; filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 XWidowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental h မ pe John M. Schiele traumatic Ester Evans Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,21771$ Department of Health ar Important: If item 27 is any injury or other trau William S. Sherman - Son 4319 Moxley Valley Drive, Mount Airy, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematorium 5/14/12 4 Donetion 5 Other (Specify) Alexandria, Virginia permit. 21. Signa ure of F neral Service Ficens 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. heres Molesworth-Williams P.A., Funeral Home Approximate Interval Between Immediate Cause (Final arterios eleroticardiovaseulas Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated sures) Examine Due to (or as a consequence oi). physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 use as yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por 5 Other (specify) Month Day Year signed by the at d be detached for Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ carrel tobullate 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed Ostevarthritis 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 page 2 s 24 hours after death.

Funeral Director: After this certificate has macular Legenerale 1 🗆 Yes 2 🗆 No the Hospital or Attending Physician: 25. Was case referred to medica. funeral director, 26. Place of Death (Check only one Be examiner? Hospital Other: 1 ☐ Yes 2 ☐ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No 1 Tes within 24 hours after death

To the Funeral Director: / 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆

State Registrar

only one) 29b. Signature and title of certifie

4.ROBERT

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 201 RNSSELL AVEN

32. Registrar's Signature

BIRSCHOAL H

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

GALTHERSBURG

29d. Date signed (Month, Day, Year) nay 12,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Randolph Sterling Michael 5 OAM 2012 Medical 1710 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Comica 11SbyRVRChab AND 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 □ F 59 Months Hours Min. 02/11/1953 225-76-5388 Director <u>Virginia</u> Usual Residence of Decedent or 28a-f shov 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits Director or other traumatic event, the Medical Examiner must be notified 1 Yes 2 No Maryland Wicomico Salisbury Baltimore, Maryland 21215-0036 1/1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 or items 23a USA 113 Overlook Dr., 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give 1971-75
Year or Dates. Black White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: White "natural". Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Officer permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Betsy Ross Baker Carl Randolph Sterling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Sterling/Son 113 Overlook Dr. 1E, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parksley Cemetery 5/7/2012 Parksley, VA Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ mhoso disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d, Date of delivery 23b. Was decedent pregnant Live Birth
Pregnant
Unknown Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Dav Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: 2 NO Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🧏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or certifie on who completed cause of death (Item 23a) (Type, Print) VA ichole 9 200 Lordduha

Registrar

State

31. Date filed (Month, Day, Year)

MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Suhr Frederick Anton 05 701Z Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4a. Facility Name (if not institution, give street and number, REGIONAL KICOM LOS Medical Cesta TENIN SULA If Under 24 Hrs . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 146-14-4681 **Director** 1 **X** M 2 □ F 85 09/02/1926 New Jersey or 28a-f show notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Chance Maryland Somerset 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō event, the Medical Examiner must be 21821 23628 Thomas Price Rd "natural", or items 23a Funeral USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Specify White 3 Widowed 4 Divorced Year or Dates. Navv Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Research Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Cornelia Fee Anton Gordon Suhr 19a. Informant's Name/Relationship (Type, Print) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23628 Thomas Price Rd., Chance, MD 21821 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Doris W. Suhr/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 🗶 Cremation 3 🗍 Removal from State any injury or 5/11/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Signal re of Funeral Survice Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Chompoor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RILIARE (10 Physician/ disease or condition resulting in death) Medical **Examiner** diseASP Sequentially list conditions, Due to (or a if any, leading to immediate cause. Enter Underlying Cause (Disease or injury death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 g Unknown g Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 a autopsy performe death? I or Attending Physician: The after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🕱 No Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending injury Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person whe

11

31. Date filed (Month, Day, Year)

MT. VELNON AD

PHACESS ANNE,

completed cause of death (Item 23a) (Type, Print)

Signature Signature

M. Q.

32

30434

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Virginia Towers 1:45 2012 ΑM Medical Mas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis HealthCare The Pines Talbot Easton If Under 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗙 F Months 08<sup>(Month</sup>1<sup>Day, Year)</sup>918 Hours Min. 217-12-4236 93 Director Md. Usual Residence of Decedent 28a-f show 10a. State injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Talbot Easton 1X Yes 2 No 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 610 Dutchmans Lane 21601 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ George Saunders Henning Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda L. James / Daughter 9893 Three Bridge Branch Rd., Easton, Md. 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Windy Hill Cemetery 1X Burial 2 Cremation 3 Removal from State 5-17-2012 Trappe, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Hurbey & Ostrowski Funeral Home P.A. Ostiwak; P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ VASCULAR Medical Due to (or as a consequence of): Examiner APDIOMYOPATHY schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invertal director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Other (specify) Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown 1 ☐ Yes ∠ ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 1 No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one

TUS

Towers

Virqinia

State Registrar 29b. Signature and title of certifier

eside c

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

R133336

DUTEHMANS LANE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month\_ Lee Todd Betty 20/1 1957P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Peninsula Regional Medical center 23115bur Wilcomico Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 218-24-5266 Director 1 □ M 2 🗶 F 82 06/23/1929 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits by Funeral Director 1 X Yes 2 No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 101 Village Oak Drive Was Deced Armed Forces? Yes 2 X No Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Episcopal Church 12 Secretary To Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or Nettie Driscoll D. Garland Tingle ge 1 and 2 should but of Health and Mer It of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Village Oak Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) Robert M. Todd Sr/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury or Department Important: I any injury or once. 5/11/2012 Salisbury, MD ■ Donation 5 ■ Other (Specify) Parsons Cemetery Signature of Funeral Service Holloway Funeral Home Professional Association > CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 X No certificate 1 Yes 2 No Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No 1 Yes Other: Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Director: After To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HO057410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3A6136414, MD M.O. 100 E. CARroll SIMONA 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / Physician/ 0814 ) Ames Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENINSULA MADICAL 546156414 NICOMICE REGIONAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 764 Hours Director 08 27.5 Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Accomack NOL 1 Yes 2 Woo 10e. Street and Numbe 10g. Citizen of What Country? Funeral 3415 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ŏ þ 1 Never Married 2 Married Maryland 21215-0036 after 1 ☐ Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Abure traumatic event, Be Department of Health and Mental Himportant: If item 27 is marked any injury or act. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည TAYlar Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code) 6Comole Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ignature of Funeral Service Licensee 22. Name and Address of Facility whapper llions CCampo 🖄 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Records, P.O. Box 68760 the as the attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Yes be detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? the Hospital or Attending Physician: The law certificate has autopsy page perform Yes 2 No Division of Vital funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 les 2 🗆 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation within 24 hours after death To the Funeral Director: Suicide 6 Could not be filled in by 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Certifying Nunce Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier uniner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Nunce Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatus and title of 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

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31. Date filed (Month

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ed cause of death (Item 23a) (Type, Print)

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ykero.		٠,	Registrar  1. Decedent's Name (First, Middle	e, Last)		Ortinoato or	204	2. Date of De	eath	2012	3. Time of Death
	Physici /Medic		Royce Regina		r.			Month May	Day 9	Year 2012	2:58 PM
1	Examin	ner	4a. Facility Name (If not institution				or Location of Death	1		ounty of Death	
		120	31170 McCormicl		(In yrs. last birthd	Princes		8. Date of Bir		omerset	place (State or Foreign
	Funeral Director		216-38-8422	1 <del>2</del> M 2□ F	70 Yrs	Months Days	Hours Min.	8. Date of Bir (Month, Da May 13		Coui	Maryland
	pu ,		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location					10d. Inside City Limits
	larylal show ed at	5	Md. Some								1 ☐ Yes 2 ☑ No
	the M 28a-f notifie	recti	10e. Street and Number	set	Princ	10f. Zip Code			10a. Citize	n of What Cou	ntry?
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	31170 McCormic	ck Swamp Road		2185	3		Unit	ed Stat	es.
	death	nera	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	3. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Span. Mexican, Puert	pecify Yes or No o Rican, etc.)		. Race - Americ Black, White,	can Indian,
2	s after , or ite		1 Never Married 2 Mar	ried 1 Yes 2 N	lo	1 Yes 2 No		, , ,		pecify:	
000	hours tural' al Exa	ed by	3 Widowed 4 Divorced	Year or Dates:	16a. De	cedent's Usual Occu	pation		16b. Kind	Whi of Business/In	
<u>n</u>	nin 72 n "na Medio	Completed	(Specify only highe	st grade completed)  College (1-4or 5	(G	ive kind of work done e. DO NOT use retire	during most of wor	king			
7	d with giene er tha	mo.	Elementary/Secondary (0-12)	College (1-401 3		vice Stat				Gas Sta	ation
	rould be filed v I Mental Hygie narked other i natic event, th	Be (	17. Father's Name (First, Middle, Robert W. Wind				18. Mother's Nan	,		,	
<u>a</u>	should I	2			10h M	ailing Address (Street		Elliot			n Codo)
=	0 0 0		19a. Informant's Name/Relations Sandra Windsor	: Wife							e, Md 21853
ע	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla	i	Date		ation - City or T	
altillinor	Pages nent of I int: If its iry or o		1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (5			ood Cemet	· · · · · · · · · · · · · · · · · · ·	2/2012	Princ	cess An	ne, MD.
<u> </u>	permit. Pages 1 a Department of Hec Important: If item any Injury or othe		21. Signature of Funeral Service		V00205	22. Name and Addre					
	10 2 2 2 2 3		Upon of		M00295	11673 Some				Anne, M	
			23a. P. T. Enter the disease, of ck, or heart failure. Lis	r complications the coused tonly one cause on each lin	the death. Do not le.	enter the mode of dyl			arrest,		Approximate Interval Between Onset and Death
F	Physician /Medical		di se or condition re ulting in death)	a. Due to (or as	Z-nenna a consequence of):	en's	DISCA	30		-	
	Examiner			Due to (or as a	a consequence on.						
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0/00,	be exi ician a burial		rooding in dodny Zaor	Due to (or as	a consequence of):						
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0	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at		5 Other (specify)	-у			Month	Day Year
<u>г</u> 5	nat the d by th etach	Phy	9 ☐ Unknown Part II. Other significant condit		ut not reculting in th	o undorlying causo gi	von in Part I	23e Did	tobacco use	contribute to	the cause of death?
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	an: Trifficat tor, pa	a	25. Was case referred to medica	al			26. Place of Dea	1  Yes ath (Check only	2 No one)	1 🗆 Yes	2 □ No
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	itient 3 DOA Ot	her: 4 ☐ Nursing H	lome 5 Res	idence 6	□Other (Spec	ify)
	ing Pl		27. Manner of Death  1. Natural 5 Pendi	28a. Date of Inju (Month, Da)	ry 28b. Tim <i>y Year)</i> Inju	ry Wo		28d. Describe	how injury	occurred	
DIVISION	ttend death. stor: /	cati	3 Suicide 6 Could	not be 28e Place of init	Inv. At home farm		Yes 2 No	28f Location	(Street and	Number or Ru	ral Route Number,
5	for Attend after death. Director: /	Certification:	4 ☐ Homicide deterr	nined 20e. Place of Injury	c. (Specify)	, street, factory, office		City or To	own, State)	rvaniber or rial	ar riouse reambor,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical C	(Check only 2 Medica	ng Physician: To the best I Examiner: On the basis o	f examination and/						
	To the within 2 To the comple	Med	one) 29b. Signature and title of certific	and manner sta	atea.	29c. Licen	se number		29d. Date	signed (Month	, Day, Year)
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3	r A	15	30. Name and address of perso	who completed cause of d	eath (Item 23a) (Ty						
	104	W 8		man 300	134 M+	Vernor	Kd Pr	rinces	SAr	nel	Nd 21853
	Sta Regist	ate rar	31. Date filed (Month, Day, Year	32. Registr	ar's Signature	1					
DHN	/IH 17 Rev 1/2		ו וחוו	32. Registr.	wa p.	gare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012  $\mathbf{P}^{\mathsf{M}}$ WILKINS 4:26 GORMAN WAYNE May 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death SUSSEX ATLANTIC GENERAL HOSPITAL BERLIN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign NOV. 26, 1961 1 X M 2 □ F Days Hours Min. MARYLAND 220-76-7036 50 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No WICOMICO WILLARDS MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21874 9430 GREENBRANCH ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) METAL STUD MECHANIC CONSTRUCTION 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILKINS WILLIAM ETHEL BRATTEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9430 GREENBRANCH ROAD, WILLARDS, MARYLAND 21874 BARBARA A. WILKINS/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 5/8/12 DELMAR, DELAWARE 21. Signature of Juneral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Yunknown 24a. Was an autopsy

Physician/ Medical **Examiner** 

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

**Funeral** 

Director

r 28a-f s notified

"natural", or items

permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Montal Office.

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Waltimore, N

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death with the Maryland

physician and s the burial-trans To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 sl

Records, P.O. Box 68760

Division of Vital

GOLMAN

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ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown
te: To Be Completed by Physician/Medical E	Part II. Other significant conditi
To Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No
e:	27. Manner of Death

Medical

29b. Signature and title of certifier

1 X Natural

Accident

24b. Were autopsy findings available prior to completion of cause of death?

performed?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Yes 2 No

3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continued Practices To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

28a. Date of injury (Month, Day, Year)

29c. License number R 135131

28c. Injury at work?
1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) May 8, 2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and a dress of person who completed cause of Pennie Savage, CRNP,

Hospital:

death (Item 23a) (Type, Print) 9715 Healthway Dr, Berlin, MD

State Registrar

GTE

31. Date filed (Month, Day, Year) MAY

5 Pending

Investigation 6 Could not be

determined

1 Inpatient 2 XER/Outpatient 3 DOA

28b. Time of

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Geraldine Mae Williams May 8, 2012 2255 p /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Delmar Manor Assisted Living Delmar Wicomico If Under 1 Year | If Under 24 Hrs. | Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 21€ F 219-14-4584 Director 88 05/21/1923 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Director 1 ☐ Yes 2xxNo Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31093 East Line Road 21875 IISA Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No ģ Specify: 3 ₩ Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Mand Injury or other traumatic event, Item Manda Elementary/Secondary (0-12) 12 College (1-4or 5+) bookkeeper retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William B. White Alice Welch ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Dickerson/son 36953 St. George Road, Delmar, DE 19940 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St Stephen's Cemetery 5-12-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E Grove St, Delmar, DE 19940 in Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List nly one callse on each line. Approximate Interval Between Onset and Death Immediate Cause Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? in the past 12 mg 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) o. 1 ☐ Yes 2 ☑ No peu the 9 Unknown 9 Unknown signed by t þ σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown 24b. Were autopsy findings available prior to completion of sause of death? 24a. Was an has page 2 certificate 1 □Yes 2 No 1 ☐ Yes 2 N/6 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 (Specify) ASCISTED LIMA Hospital: 1 Tes 2√No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After that in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide the Hospital within 24 hours a 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

BX State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

710 31. Date filed (Month, Day,

10 2012

Year

29b. Signature and title of certifier

32/ Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:20PM Joseph Andrew Zator Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** at the vastal Hospice 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min (Month, Day, Year) 161-28-8109 Director 1 X M 2 🗆 F 79 08/27/1932 Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 XNo Maryland Wicomico Salisbury 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 201 Spring Crest Drive 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working should be filed within 72 ho h and Mental Hygiene. 7 is marked other than "na 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or access. ပ Andrew Zator Adeline Trelinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcella E. Zator/Wife 201 Spring Crest Dr., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory 5/12/2012 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD nature of Funeral Service Licensee Holloway Funeral Home Professional Association Chompson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ASCVI Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🗎 Probably 🛂 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate No No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes № ☐ No Other: ဂ္ asbuc 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of Naturai 5 Pending 2 🗌 No Accident Suicide Investigation completely filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

29b, Signatur

and title of certifier

MAY

31. Date filed (Month, Day, Year)

VOHPA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN

32. Redistrar's Signature

29c. License number

D 63199

HOLE

DR. SALISBURY.

29d. Date signed (Month, Day, Year)

10/12

Lanell Orlando A	usb		f Maryland / Depa				gibie.	
		1- For State Registrar		rtificate of			eg. No. 201	2 172
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last)	do AK	by		2. Date of Dea Month May 26, 2	th	3. Time of Death 0628 hrs
3		4a. Facility Name (if not institution, give s	treet and number)	4k	o. City, Town, or Location	on of Death	4c. County of Deat	n
		Sinai Hospital			Baltimore		NA	
Funeral		Social Security Number     6. Sex	7. Age (In yrs. I	ast birthday)		nder 24Hrs. 8. Date of Bi	th(MM/DD/YYYY) 9. Bi Forei	
Director		220270081 V	1 2 F	Yrs.	Wionans Bays The	Feb 15	1990 c	ountry) ///
any	-	Usual Residence of Decedent  10a. State 10b. County	I10c. City	, Town or Location	n			10d. Inside City Limit
		mp Nh		Himore				1 Yes 2 N
Maryland 28a-f show d at once.	횽	10e. Street and Number	Du	mmare	10f. Zip Code		0g. Citizen of What Cou	ntry?
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	1557 Winston	Ave.		21239		USA	
with or 23.	ज्ञ	11. Marital Status	2. Was Decedent Ever in U	.S. 13. Was	Decedent of Hispanic	Origin? (Specify Yes or No can, Puerto Rican, etc.)	P - Q7 1	ican Indian, Black,
death	Fune	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No				0	look
s after	2	3 Widowed 4 Divorced If placed Divorced Divorced If placed Divorced Divo	r Dates:		res 2 No speci s Usual Occupation (Gi		Specify: 16b. Kind of Business	Industry
2 hour	ğ	Elementary/Secondary (0-12)	College (1-4 or 5+)		et of working life. DO N		Tob. Aire of Business	and do y
D36 thin 7 re.	Completed	, , , ,	Vr	Drive	~		Rental	L'ars
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica	S	17. Father's Name (First, Middle, Last)	• 1		18,Mot	her's Name (First, Middle,	Maiden Surname)	
121 d be fi ental	Be	Don Lausion	2:11	Lan Maria		sther 11)00	ore	71.0-10
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٦	19a. Informant's Name/Relationship (Typ	- mother	196. Mailing /	Winston	Number or Rural Route Nur Ave. Bojt		2 20 Code)
mand 2 sho tealth and tem 27 is traumat	ŀ	20a. Method of Disposition	20b.		on (Name of cemetery,		20c. Location - City or	Town, State
10re 10re 11 of H		1 Burial 2 Cremation 3	Removal from State	crematory or othe	r place)	1-2-12	Randalla	town mr
	ł	4 Donation 5 Other Specify:  21. Signature of Funeral Service License		22. Na	me and Address of Fac	ility	riu muis	21270
Balti permit. Departn Imports		Smull I /mel		Gor	y P.Morch	FH270 FRY	thi HonPass	Ballo mo
Physician		23a Part I Into the disease, or complications. List only one cause on each		. Do not enter the	node of dying, such a	s cardiac or respiratory arr	est, shock, or heart	Approximate Interva Between Onset and
/Wedical Examiner	ı	Immediate Cause (Final disease a. M	ultiple Gunshot Wour					Death
	- 1		e to (or as a consequence o	rf):				
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	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence o	·f):				1
kecuted n and - transit		events resulting in death) Last d.						
ੂਲ ਲੋਕਾ	sician/Medical	UNPENDED	AMENDED					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buni	₩ .	IF FEMALE:	23c. If yes, outcome of preg	nancy			23d. Date of deliver	
Box 68760 e death certificate b the attending physied for use as the bu	ä	23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at time of de	ath -		opic pregnancy	Month	Day Year
30x death ne atte	hysic	1 Yes 2 No 9 Unknown	9 Unknown	J Otne	er (Specify)			
O. I	۵.	Part II. Other significant conditions co	ontributing to death but not r	esulting in the un	derlying cause given in		obacco use contribute to	
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ords w requ	ompleted					24a. Was autor	sy prior to	utopsy findings available completion of cause of
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Physical directions	힏	1 ✓ Yes 2 No	pital: 1 Inpatient 2	ER/Outpatient 28b. Time of Inju			Residence 6 Othe	r.
ion of ' tending Ph eath. ior: After t	<u>ë</u>	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) May 26, 2012	0127 hrs	1 Yes 2	— ISubject sho		
IVISIOR or Aftence death Director:	Certification:	2 Accident Investigation	28e. Place of Injury - At h	ome, farm, street,	1111		Street and Number or Ri	ural Route Number, City
Divisi pital or Ati ours after d eral Direct filled in by		3 Suicide 6 Could not be determined	(Specify) Parking Lo			or Town, S	State) dgecombe Circle , Ba	altimore , MD
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b			: To the best of my knowled	ge, death occurre	d at the time, date and	place, and due to the caus	se(s) and manner as sta	red.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: 0	n the basis of examination and manner stated.	nd/or investigatio	n, in my opinion, death	occurred at the time, date	and place, and due to the	ne cause(s)
	Ž	29b. Signature and title of certifier			29c. License numb	per	29d. Date signed (Mo	nth, Day, Year)
		Mu -	KN	11	O.C.M.E.		May 27, 2012	
		36. Name and address of person who cor Russell Alexander MD. As	npleted cause of death (Item ssistant Medical Exan		/ Baltimore Stree	et Baltimore MD 21	223	
<u> </u>	ate				. Daminore one			
Regist	rar	31. Date filed (Month, Day, Year) 2 JUN 0 I 2012	Zerova B.	garle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g928 6-15-12 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 9:55 M Medical icility Name (if not institution, give street and number)
1436 E. Fort Avenue 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 9**220**6 ecurity Number 222-18-5666 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6/7/27 Funeral 6. Sex 7. Age (In yrs. last birthday, Days Min. Director 84 1 M 2 XF Yrs MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 5.8 and 28a-f sho in injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City N/A MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral I 21230 1436 E. Fort Avenue USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 2 **XX** 1 Yes 2 XXX Specify: 3XXWidowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surpame Mary Lewandowski 17. Father's Name (First, Middle, Last) 2 Walter Rykowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 642 B. Street, Pasadena MD 21122 642 B. Street, Pasadena MD Mary E. Siemer /Daughter Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Ardent Crematory or other place 1 Burial XX Cremation 3 Removal from State Hanover Maryland 5/23/2012 4 ☐ Donation 5 ☐ Other (Specify) S mature of neral Saures Licensee Victor P. Charles L. Stevens Funeral Home, Inc G 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Pregnant at time of death Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 1 Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? after death. ☐ Accident ☐ Suicide Investigation Could not be within 24 hours after de To the Funeral Director completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) (Mem 23a) (Type, Print) Name and address son who completed cause of death State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ May 30 Gloria L. Bledsoe 12:54 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Glen Meadows Glen Arm Baltimore 8. Date of Birth (Month, Day, Year)
Anril 22,1927 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 K F Director 217-24-1262 85 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Goodale Place 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 💢 No Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify. White Completed 3 Widowed 4 Divorced Specify: Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ <u>Teacher</u> Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James L. Whittle Viola Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Bledsoe (Daughter) Goodale Place Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Other (Specify) Hilltop Service Corp. 5/31/2012 Towson Maryland 21. Signature 22. Name and Address of Facility 21204 Chas Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease, or complications that causeur carbeart failure. List only one cause on each line , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Tarle months Medical Due to (or as a consequence of): Examiner months Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 🖁 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location /Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on re and title Ro79544 30. Name and address of person wito completed cause of death (Item 23a) (Type, Print) CHARLES 85 (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ BRANDEN 12:21 AM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death ECOURS tos P m Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 - M 2 -Months Days **Director** 218-46-6138 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 K Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1800 Hollins Street Apt. #212 21223 USA within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. permit, Page 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married Maryland 21215-0036 African If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 → Widowed 4 □ Divorced Completed American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Home maker Domestic Be any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell Ridley Inez Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaTonya M. Gaulteau-Daughter 4205 Hamilton Avenue Baltimore, Maryland 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Mem. 20c. Location - City or Town, State Date 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State 06-04-12 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or linjury ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death should be detached ed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available has page 2 prior to completion death? performed?

Yes 2 No AF certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred o medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Hospital 2 - No Other: 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manuer of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 2 No Accident Suicide Investigation Could not be s after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and till 29c. License number person who completed cause of death (Item 23a) (Type, Print) W

State Registrar BonSecours Hospital 2000 W. Baltimore Street

BESONER, BLANCHE MAY 29,2012 0100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7, 8, per fh, g928, 6-27-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ 29<sup>Day</sup> 2012 Blanche F. Besoner 0100 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** <del>89</del> 90 **Director** 228-16-0321 1 □ M 2 🛣 F Virginia -22-1922 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director MD Montgomery Rockville 1 Yes 2 No 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? ms 23a or Funeral 13303 Grenoble Drive 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iter Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 Divorced er than "natur the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit, Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any highry or other traumatic event, the Monee. Tech. Info. Speciallist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jacob Freeman Sadie Schulman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dena Saunders - Daughter 427 Sternwheeler Ct., Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-31-2012 Judean Mem. Gardens |Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Brad Smetzer 1091 Rockville Pike, Rockville, Maryland, 20852 23a. Part 1. Enter the disease, of shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line Interval Between Onset and Death Immediate Cause (Final gallbladder Physician/ cancer disease or condition resulting in death) Medical Due to or as a consequence of **Examiner** 1 weck 6 EP515 Esquentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe death? 1 ☐ Yes 2 ☐ No 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 2 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending injury 1 Natural s after decal Director: After 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours Funeral Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Dav. Year. MD 70144 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Middlen/ Center Drove Forleville, Monn in C 9901 Michael Murroy MD 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 0 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:510 Medical Examiner Facility Name (ii not institution, give, street and number) City, Town, or Location of Deatl 4c. County of Death 0 8. Date of Birth (Month, Day, Year) If Under **Funeral** 9. Birthplace (State or Foreign Months Hours Country Director 180-46-6284 1 🗆 M 2 🔀 F 58 17, 1953 Pennsylvania item 27 is marked other then "neturel", or iteme 23e or 28e-f show other treumatic event, the Medical Evarance must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Fairfax 0akton /irginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera U.S.A. 12000 Wandabury Road 22124 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Group Vice President Oracle Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I မှ Spindler Robert Fleming Genevieve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 12000 Wandabury Road, Oakton, Virginia 22124 of Health a Samuel Bickford/Husband Baltimore, Department of He important: If he eny init: 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Money & King Cremation 5/30/2012 Chantilly, Virignia 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furneral Service Licensee 22. Name and Address of Facility Money & King Funeral Home, Inc. Gary R.Downer 171 W. Maple Ave., Vienna, Va. CCO 508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MYELODYSPLASTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated agents Exami Hospitel or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the ar 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 N Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes Other: 2 🖼 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

lerel Director: Aft
filled in by the fu 2 ☐ Accident 3 ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hoepitel within 24 hours a To the Funeral C completely filled Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 Orleans MEYER MOPHD 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Howard May 29, 2ัดี12 8:00 AMM Bangert Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 5515 Bush Street White Marsh Baltimore al Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Davs Hours Min 214-30-4037 **Director** 1 X M 2 □ F 2/17/1933 Maryland 79 Yrs Usual Residence of Deceden or 28a-f show notified at 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore White Marsh 50 23a c t be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with must 21162 5515 Bush Street S. items death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or ite the Medical Examiner Armed Forces?

1 X Yes 2 \( \square\) No Black, White, etc. Completed by 1 Never Married 2X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Yes, Give 3 Widowed 4 Divorced Specify: Year or Dates 1955 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 11 / Operator Owner Television Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Bangert Kellner Barbara 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Armen Agnes Bangert (Wife 5515 Bush Street White Marsh, Maryland 21162 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important; If it any injury or o once. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gard. 6/4/2012 Middle River, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21, Signature of Funeral Service Licenses Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Estet marity Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physiciar Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No jo Month Dav þ been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 X No page certificate Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 1 ☐ Yes 2 XNo ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

9512 Harford Road

Baltimore,

Suite 4

MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Ranhnama

UN O 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM# / per FH, G928, 6/6/2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Month Physician/ ANNA E. BAUER 11:20P 27,2012 MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 130 CARRIAGE LANE ELKTON CECIL CO. 5. Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours 214-24-5831 1 M 2 X **Director** 2-6-1930 MARYLAND 82 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No CECIL ELKTON MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n 6 Funeral USA 21921 130 CARRIAGE LANE death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Examiner Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Sec 12TH condary (0-12) College (1-4 or 5+) ACCOUNTANT SPECIAL EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HENRIETTA A. STANG CHARLES A. GAGALSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATONSVILLE, MD. 21228 1002 WOODSDALE ROAD LINDA M. OLSZEWSKI DTR. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) **PARKWOOD** 5-31-2012 PARKVILLE, MD. 21. Signature of Euro Service Linensee 22. Name and Address of Facilit SCHIMUNEK FUNERAL HOME OF BEL AIR 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 rt 1 Enter the disease or complices, or heart failure. List only one ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part Immediate Cause (Final disease or condition resulting in death) earn ap 14 Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death for in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the sause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò page 2 should be 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available Was an prior to completion of cause of death? actopsy perform 2 No 1 Yes 25. Was case referred to medical examine 2

1 Yes No filled in by the funeral director, Be 26. Place of Death (Chronoly one) Other: 4 Nursing Home မ 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury s after death. 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical within 24 hou To the Funer completely fi 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Name and address of person 31. Date filed (Month, Day, Year) 32. Registrar's State JUN 0 1 2012 Registrar

## Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

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п	/Medical	MARY ANNE BARVII				4h City Town o	r Location of Daati		of Death	9:15A.
	Examiner	4e Fecility Neme (If not institution, give s TRANSITIONS HEAL)				SYKESVI		, o. county		DOT T
	Funeral	5. Social Sacurity Number 6. Sax	7. Aga (In yrs. la	ast birthday)	If Undar 1 Yaar Months Days		rs. 8. Data of Bir	th Year)		ROLL laca (State or Foreign try)
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	vith the Mar t or 28a-f s be notified Director	10e. Street and Number		DIR	10f. Zip Code			10g. Citizan of V	Vhat Coun	try?
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Maryland 21215-0036	72 hours after death with the Marylend naturel, or items 23s or 23s-f show deal Examinet must be notified at eted by Funeral Director	11. Marital Status  1 Naver Marriad 2 Married  3 Widowed 4 Divorced	12. Was Dacadant Evar in U,5 Armad Forcas? 1 ☐ Yas 2√ No If Yas, Give Yaar or Datas:				(Spacify Yas or No arto Rican, atc.)	14. Race Blace Specify	e - Amaric k, Whita,	
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J.	alth e 27 la	EDWARD J. BARVIR	SON		1202 CO	URTLAND	DRIVE S	YKESVILI		
	S to E	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other pla		Date 6-2-201	20c. Location -		wn, Stata
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	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A complately filled in by the fi	29a. Certifiar ACertifying Physical Conditions (Check only one)	sician: To the best of my knowner: On the basis of examinal and mannar stated.	wledge, death tion end/or in	occurred at the t vastigation, in my	ime, date and pla opinion, death o	ace, end due to the ccurred at tha time	, date and place,	end due t	o the cause(s)
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	State Registrar	31. Data filed (Month, Day, Year) JUN 0 1 2012	mplated cause of daath (Itam  (MOUD)  32. Ragistrer's Signa	tura						

DHMH 16 Rev 6/95

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month 5:05 ам Beulah Bew May 29 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7466 E. Furnace Branch Road Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Country) 1 🗆 M 2 💢 F **Director** 215-18-5857 Usual Residence of Dece Yrs 88 August 28,1923 Maryland 28a-f show 10b. Count the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified MD 1 🗌 Yes 2 🙀 No Anne Arundel Glen Burnie 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? pe and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a by Funeral items 23a ner must t 7465 E. Furnace Branch Road 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress <u> Upholstery</u> Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Abraham Handler Sarah Goldstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Kleinsmith daughter other 1 <u>7762 E. Shore Road Pasadena, </u> 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Cedar Hill Cemetery June 1, 2012 Brooklyn, Maryland 22. Name and Address of Facilit McCully Polyniak Funeral Home P. A. 21. Signature of Euneral Service Licensee 1270 3204 Mountain Rd. Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death ill lungra and o Medical resulting in death) Due to (or a a consequence of): **Examiner** Weeks to Month course Sequentially list conditions Cun to Ur as a consequence of) it any leading to immedicause. Enter Underlying burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? 2 No been signed by the a should be detached 1 Yes 2 J g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy perform this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 88 31. Date filed (Month, Day, Yelf)
JUN 0 1 2012 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year MAY 4:03A 25 nningham Medical 4a. Facility Name of not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL BALTIMORE TOWSON CENTER Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 37-66-9020 Hours Country) **Director** 1 ■ M 2 □ F vorth or 28a-f shorn 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timor 10e. Street and Number ò 10g. Citizen of What Country? pe must be Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or ite Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give 1 ☐ Yes 2 ☑ No Completed 3 Widowed 4 Divorced Year or Dates. event, the Medical Baltimore, Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stonewood alto. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 53 23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee STROKE Immediate Cause (Final Ph, sician Onset and Death
YEARS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** YEARS DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) RECURRENT ASPIRATION YEARS Cause (Disease or injury that initiated events and as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Physician: The law requires that the death certificate be of Vital Records, P.O. Box 68760 IF FEMALE: ate has been signed by the attending page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 X/No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Inpatient 2 🕽 ER/Outpatient 3 DOA fter this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury Division Accident Suicide 2  $\square$  No Investigation filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JUN 0 1 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Robert J. Crandall 2. Date of Death Physician/ Month 2017 MAY 540M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) 65 n yrs 215-46-5987 1X M 2 □ F Months Hours Min Month Day Y **Director** MD Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Anne Arundel Glen Burnie MD 1 Yes 2XXVI ריאסרי אסריאן Baltimore, Maryland 21215-0036 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 341 Gatewater Landing, Apt 203 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

124 Yes 2 No Army
If Yes, Give Vietnam
Year or Dates. Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Service Cook Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Sablowski Crandall ပ Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 Alden Street, Baltimore MD 21225 Carol A. Hasselberger /Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cem 6/1/12 Crownsville Maryland 22 Name and Address of Facility Charles L. Stevens Funeral Home, I 1501 E. Fort Avenue, Baltimore MD Doda reconfruneral Service Licensee Victor P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph<sub>sician</sub>/ NELMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine burial-transi Cause (Disease or linjury METTABOLC M-3DIMANM and that initiated event resulting in death) Last Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death detached g Unknown as been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has funeral director, page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2d No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မှ After this 27. Mayer of Death 28a. Date of injury 28b. Time of Certificate: 28c Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) iniury 1 Natural 5 Pending Accident Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titi 29c. License number 29d. Date signed (Month. Day. Year)

State Registrar

DHMH 17 Rev 7/2009

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301 Hose Prive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MSMirona

BALD'NOM-

31. Date filed (Month, Bay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ E. COOKSON 650,7M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice at Northwest Hospital Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Director 293-28-1723 1 □ M 2 🗓 F 76 July 7, 1935 0klahoma Usual Residence of Decedent 28a-f show 10b. County the Maryland 10c. City, Town or Location must be notified at Director 10d. Inside City Limits Maryland Baltimore Woodstock 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3004 Granite Road 21163 United States permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner munone. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 🛮 Widowed 4 🗆 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Andrew Joseph Mietus Elizabeth Ann Mezaros 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Andrew Cookson/Son 3004 Granite Road, Woodstock, Maryland 21163 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery June 4 2012 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 Will Estanes M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes Yes 2 AON 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner? 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Blud Glen Burnie 210 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

only one)

29b. Signature and title

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death								
			Reg. No. 2 1. Decedent's Name (First, Middle, Last)  2. Date of Death								
н	Physicia		, ,	David	Coates			Month May		Year 012 6:16 P M	
- day	Medic Examin		4a. Facility Name (if not institution,		Joaces	4b. City, Town, or	Location of Deat		4c. County of		
· j			Holy Cross Hos	pital		Silv	er Spri	ng		ontgomery	
	Funeral		5. Social Security Number	"	e (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min			Birthplace (State or Foreign Country)	
	Director		579-46-6943 Usual Residence of Decedent	1 XM 2 □ F	74 Yrs	1 /		1		Vashington D.C.	
	und show at	5	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	naryla 8a-f tified	ect	MD Mont	gomery		Silve:	Spring			1 ☐ Yes 2 No	
	the la or 2 or 2 or no	٥	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?	
	n with	Funeral Director	2101 Fairlar	d Rd.			20904		Unite	d States	
36	is filed within 72 hours after death with the Maryland tal Hygene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 X Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	ver in U.S. 1	<ol> <li>Was Decedent of Hill If Yes, specify Cuba</li> <li>Yes 2 No</li> </ol>		pecify Yes or No- to Rican, etc.)		American Indian, White, etc. Black	
21215-0036	hours natur lical E	Completed	15. Deceder	Year or Dates. t's Education		cedent's Usual Occup			16b. Kind of Busi	ness/Industry	
215	e. nan "l	Ĕ	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-4 or 5	116-	ve kind of work done of DO NOT use retired)	luring most of wo	rking		,	
21	d within ygiene. her tha	Be C				Oriver				g Company	
Maryland		To B	17. Father's Name (First, Middle, L (Unknown)	ist)			18. Mother's Na	me (First, Middle, i		oates	
Ž	2 should be file th and Mental I 27 is marked o traumatic eve		19a. Informant's Name/Relationsh	in (Type Print)	10h M	ailing Address (Street a				-	
	2 ± 2 ±		Carla Walker /	1 1 // /		D2 Bonny D				20747	
ore,	le 1 and 2 t of Healt If item 2 or other		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place	el .	Date	20c. Location - C	ity or Town, State	
<u>ii</u>	Page ment c ant: If ury or		1 ☐ Burial 2 <b>X</b> Cremation 4 ☐ Donation 5 ☐ Other (S	3 L. Removal from State pecify)		ake Cremat		29/2012	Be1tsv:	ille, MD	
Baltimore,	20c. Flace of Disposition (Name of 1   Date 20c. Location - Cit 1   Burial 2 X Cremation 3   Removal from State 4   Donation 5   Other (Specify)  21. Signature of Fupper Service Disposition (Name of 1   Date 20c. Location - Cit 2   Chesapeake Crematory or other place)  22. Name and Address of Facility  23. Signature of Fupper Service Disposition (Name of 1   Date 2   Da								20910		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between	
f	Immediate Cause (Final disease or condition resulting in death)   ACUTE CARDIORESPIRATORY FAILURE								Onset and Death .		
-	Medical Examiner		resulting in death)  Due to (or as a consequence of):  CHRONIC HYPERTENSION								
		ier	Sequentially list conditions, it any, leading to immediate	D. —	C HYPERT	ENSION					
	ted 1 ansit	ä	cause. Enter Underlying Cause (Disease or injury	· ·	SON"S DI	SEASE					
Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
68760	rtifica ling pl e as t		IF FEMALE:		,						
Box (	death certifi ne attending ed for use a	ian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth 2 4 Pregnant at	2 Fetal death	Ectopic pregnanc	у		23d. Date Montl		
m m	he de	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time of death	United (Specify)					
P.O.	Attending Physician: The law requires that the ar death.  **ra death.**  **ra dea	by PI	Part II. Other significant condition	ns contributing to death bu	ut not resulting in th	e underlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?	
ds,	quires en sign uld b		*****					1 🗆 Y	′es 2 □ No 3	☐ Probably 4 🛭 Unknown	
Ö	w rec as bee 2 sho	Completed						24a. Was a		re autopsy findings available or to completion of cause of	
Rec	The la	Sol.						autop perfor 1  Yes		ath?	
<u>e</u>	sian: ertifica ector,	Be (	25. Was case referred to medical examiner?			26. Pla	ace of Death (Che				
Ž	Physic this c	유	1 Yes 2 X No		nt 2X ER/Outpat		4 U Nursing I		ence 6 🗆 Other (	(Specify)	
0 U	ding F h. After funer	ate	27. Manner of Death  1 X Natural 5 □ Pending			work	?	28d. Describe ho	ow injury occurred		
Sio	Atten deat ctor: by the	Certificate:	2 Accident Investig 3 Suicide 6 Could r	ot be	rv - At home, farm	M 1 🗆	Yes 2 No	28f Location (St	treet and Number	or Rural Route Number,	
Division of Vital Records,	al or safter		4 ☐ Homicide determi	building, etc.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town		r rurar route rumber,	
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier XX Certifying (Check 2 Medical Ex	Physician: To the best of n	ny knowledge, deal	h occurred at the time	, date and place,	and due to the car	use(s) and manner	as stated. the cause(s) and manner stated.	
	the H hin 24 the F mplete	Me	only one) 3 L Certifying	Nurse Practitioner: To the	best of my knowled	ge, death occurred at ti	ne time, date and p	at the time, date ar	e cause(s) and mar	o the cause(s) and manner stated.	
	vit o		29b. Signature and title of certifier	6 4-	m	29c License	number	- 2	29d. Date signed (#		
			30. Name and address of person v	)	att (the Vac ) =	Dian D	3271		MAY 24	4, 2012	
	JV		PATRICIA GOMEZ				GAITHERS	BURG, MD	20898		
	Stat	е	31. Date filed (Month, Day, Year)		r's Signature						
	Registra	ır	HIN O I KINZ	[ Marsh B.	A STATE OF THE STA						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:15 AM May 2012 Kay Chase Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4515 Dresden St. Kensington Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Director 213-90-9290 1 □ M 2XXF 46 July 9, 1965 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a, State 10c. City. Town or Location death with the Maryland Director must be notified 1 Yes 2 X No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Funeral 4515 Dresden St. 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 🏋 No Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Health Care / Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Medicine Registered Nurse and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ Demmy Marzo1f Donna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 4515 Dresden St., Kensington, MD David D. Chase / Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 05/31/2012 Beltsville, MD M00382 Rapperdagra1 and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Promician/ OVARIAN CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Division of Vital Records, P.O. Box 68760 phy as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 ANo Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ※XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 autops\ this certificate has performed? death? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home XX Residence 6  $\square$  Other (Specify) Hospital 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After XX Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63748 Docelline, MAY 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 21218 JOCELYNE KOUATCHOU M 201 E. University Pkwy. Baltimore, MD

Registrar

31. Date filed (Manth, Pay Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Wal Medical acility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death OWSON If Under 24 Hrs. 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Mir **Director** 1 🗆 M 2 🖭 March Usual Res 28a-f show items 23a or 28a-f shoner must be notified at 10b. County with the Maryland 10c. City, Town or Location Director Ma 1 Yes 2 No more 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21 vocwithin 72 hours after death 12. Was Decedent Ever in Ja.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Armed Forces Black, White, etc. ō by 1 Newer Married 2 Married 2 NO Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 Yes 2 No "natural", Completed 3 ₩idowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industr (Give kind of work done during most of working (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the tousekee Be 17. Father's Nan (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury externs 2 Mari 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and lton timore Mark Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of crematory or other 1 Burial 2 Cremation 3 Removal from State Boultimore, Maryland uneladola STANIS 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Itumore Maryland 212 Part 1. Enter the disease, or coordinate plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ autil anzwzysu disease or condition resulting in death) Medical as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Vear Pregnant at time of death ed by the a Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy perform this certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ဂ္ 1 Tes 2 No 4 Nursing Home 5 Residence Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA nosico Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending work? 2 No Accident Investigation filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 2012 Live 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Touson

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Registrar's Signature

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Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOHN STEWART CROUCHER MAY 29, 2012 11:00 A. Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE TOWSON BALTO. If Under . Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days Min. (Month, Day, Year) 216-14-4279 90 1 ₹ M 2 □ F **Director** Yrs 5-13-1922 MARYLAND Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at the Maryland 10c. City, Town or Location 10d. Inside City Limits Director BEL AIR HARFORD MD. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by 0mce. 21014 USA <u>746 HICKORY LIMB CR</u> Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XIo Specify. WHITE 3 Widowed 4 Divorced Specify: Completed Year or Dates 1944-1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 Elementary/Secondary (0-12) College (1-4 or 5+) PLANNER/ESTIMATOR U.S. GOVERNMENT Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN T. CROUCHER ELIZABETH HABERSACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPOUSE 746 HICKORY LIMB CR. BEL AIR, MD. 21014 JOSEPHINE CROUCHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 6-2-2012 PARKWOOD CEMETERY PARKVILLE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on the line Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 1 Yes 2 9 Unknown sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 3 Probably 4 Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 Z No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No 은 1 Inpatient 2 Inpatient 3 Inpa 6 Other (Specify) 10-301 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 A Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar

JUN 0 1 2012

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29b. Sig

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N- Charles

29d. Date signed (Month, Day, Year)

Townson M

12-04052	
A COL	_

12-04052 William R. Cowley	1- For State	ack Indelible Ink. Ensi Department of Health a Certificate of Death	and Mental Hygiene	gible. 2012 172{ 19. No.
Physician/ Medical Examiner	Registrar  1. Decedent's Name (First, Middle,Last)  WILLIA	Day Year 1937 hrs		
	Facility Name (if not institution, give street and number)     Harbor Hospital	4b. City, Town, Baltimore	or Location of Death	4c. County of Death
Funeral Director	217-52-3875	e (In yrs. last birthday) If Under 1 Y 64 Yrs. Months D		h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
Azryland 128a-f show any ector	Maryland Anne Arundel		Baltimore	10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number  115 Ninth Avenue	10f. Zip Code	21225	og. Citizen of What Country?  USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year V	If Yes, specify Culling  No  iet Nam  1 Yes 2 X		14. Race - American Indian, Black, White, etc.  Specify: White
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam Completed I	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5	during most of working		16b. Kind of Business/Industry  Baltimore City
1215-0036  1 be filed within 7 ental Hygiene.  The Modien than went, the Medica Be Comple		Christian Cowley	18. Mother's Name (First, Middle, M Helen Joy Vankir	rk
MD 21. nd 2 should the should the strength of the marmatic even	· ·	ife) 115 Ninth Av	eet and Number or Rural Route Num renue, Baltimore, Mary	land 21225
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tra	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee Keyin, F. F.	Cedar Hill Cemetery	6/1/2012	20c. Location - City or Town, State  Baltimore, Maryland
	16	237 E. Pat	apsco Ave., Baltimo	miak Funeral Home, P.A. ore, Maryland 21225-1856
Physician Examiner	23a. Part I. Enter the disease, or complications that caused to failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Council Due to (or as a consecutive condition).	Cardiovascular Disease	ig, such as cardiac or respiratory arre	st, shock, or heart Approximate Interval Between Onset and Death
ted nsit <b>Examiner</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in leath). Last			
executed an and al-transit ical Exa	d			
ox 68760, ath certificate be attending physici or use as the buri	UNPENDED AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED  23c. If yes, outcom 1 Live birth 4 Pregnant at the pregnant at	2 Fetal death	B Ectopic pregnancy	23d. Date of delivery  Month Day Year
s, P.O. Bo ires that the de signed by the d be detached f ed by Phy	Part II. Other significant conditions contributing to death drowning	but not resulting in the underlying caus		pacco use contribute to the cause of death?
Division of Vital Records, P.C halor Attending Physician: The law requires that is after death.  In Director: After this certificate has been signed led in by the funeral director, page 2 should be death srtification: To Be Completed by			24a. Was a autops perform	prior to completion of cause of death?
Vital F nysician: nysician: director, 1	25. Was case referred to medical examiner?  1 V Yes 2 No  Hospital: 1 Inpatien	26.Pla nt 2 ✓ ER/Outpatient 3 DOA	ce of Death (Check only one)  Other Nursing Home 5 F	Residence 6 Other:
Division of Vision of Vision of Vision of Attending Physion of Attending Physion of Tilled in by the funeral direction of Tilled in by the funeral direction of Certification: To	27. Manner of Death  1 Natural 5 Pending 28a. Date of Injun (Month. Day Ye May 28, 2012  Accident Investigation	1915 hrs 1	Yes 2 No Subject beca	ow injury occurred ame unresponsive after belly flop
Divis	4 Homicide determined (Specify) Swif	ury - At home, farm, street, factory, office	or Town, St	reet and Number or Rural Route Number, City ate) e, Brooklyn, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatic	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exam and manner stated.	-		
	29b. Signature and title of certifier  Yuman Douthall, Ma	0.0	c.M.E.	29d. Date signed (Month, Day, Year) May 29, 2012
10+1	30. Name and address of person who completed cause of de Pamela E. Southall, MD Assistant Medic	cal Examiner 900 W. Baltimo	ore Street, Baltimore, MD 21	223
State Registrar	31. Date filed (Month, Day, Year) JUN 0 1 2012	s Signature		
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Milton Dwayne Chmielewski	State of Maryland / Department of Health and Mental Hygic

2012		7	2	8	8
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	1- For State Registrar		Certif	ficate of	Death			R	eg. No.		. , _
Physician/	Decedent's Name (First, Midd	lle,Last)					2.	Date of Dea	ith		Time of Death
Medical Examiner	Milton Dw	vayne (	Chmielews	ski			i	Month May 22, 2	Day Year 2012		1650 hrs
	4a. Facility Name (if not institution				o. City, Town, or	Location of	f Death		4c. County o	f Death	
	9710 Bon Haven Land	е			Owings Mil	ls			Baltimore	e County	1
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Yea	r If Under	24Hrs.	8. Date of Bir	rth (MM/DD/YYYY)		ace (State or
Director	217-76-9141	1XM 2F	52	Yrs.	Months Day	s Hours	Min.	12/07/	1959	Foreign Countr	Maryland
	Usual Residence of Decedent	12 2	52	113.	<u> </u>			12/01/	1555		· Haryrana
any	10a, State 10b. County		10c. City, To	wn or Locatio	n					10	d. Inside City Limits
<b>.</b>	Manage Dall		Q =	- M-11	_					1	Yes 2 X No
Maryland r 28a-f sh ed at once irector	Maryland Balt  10e. Street and Number	imore	OWING	gs Mill	10f. Zip Code			11	0g. Citizen of Wh	at Country	?
death with the Maryland or items 23s or 28s-f show must be notified at once.					Tol. Zip oode			- 1	og. Chizon of VIII	ut Ooding y	
r death with the or items 230 or must be notified Funeral Dil	9710 Bon Haven				2111				U.S.		
th wi	11. Marital Status 1 Never Married 2 M	12. Was Dece	dent Ever in U.S.		Decedent of His s, specify Cubar				14. Race White		Indian, Black,
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s afte real", by		orced If Yes, Give Year or Dates:			Yes 2 X No				Specify: W		
hours Exam	15, Decedent's Education (Spe				s Usual Occupa st of working life				16b. Kind of Bus	iness/indu	stry
5-0036 ed within 72 hours tygene. the Medical Exam Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)								
Med Med	12	1 1		Desi	lgn Engi		11 - 15		Defens		ustry
Hyg Hyg	17. Father's Name (First, Middle							irst, Middle, i	Maiden Surname)		
121 d be fi lental sarked arked; vent,	Milton A.	Chmiele		40h Mailian		Marga		L.			0-1-)
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 77 is marked other than numatic event, the Medica To Be Comple	19a. Informant's Name/Relations		ļ		· ·				nber, City or Town		
y, MD 21215-0036 and 2 should be filed within 72 hours after fealth and Mental Hygiene. treau 27 is marked other than "natural", traumatic event, the Medical Examiner To Be Completed by F	Vanessa Hill (I	Daughter)	Laob Die		OLD MIL ion (Name of ce			ings M	ills, Ma	rylar	nd 21117
S lan	20a. Method of Disposition  1 Burial 2 X Cremation	n 3 Removal fro		natory or othe		metery,	L	ale	20c. Location 2	City of 10w	VII, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Witem 37 is marked other than "natural", or items 23a or 28a-f ah injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	4 Donation 5 Other S			ntic (	rematic	n	05/2	4/2012	Glen Bu	rnie,	, Maryland
Baltil permit. Departm Importa	21. Signature of Fuheral Service		00-732	22. Na	me and Address	of Facility					
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Physician	23a. Part. Enter the disease, or		used the death, Do							irt A	Approximate Interval
/Medical	fallure. List only one cause	on each line.	lcobol ar	nd Oxy	odone 1	ntoxi	cati	on		'	Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or es a consequence of):								-			
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8760, ificate be g physic s the burn	IF FEMALE: 23b. Was decedent pregnant in the		utcome of pregnan th		I death 3	Ectopic	pregnancy	,	23d. Date of o Month	Day	Year
Sox 68° death certificate attending for use as I ysician	past 12 months?		nt at time of death		er (Specify)					•	
D. Box 68 the death certif by the attending sched for use as	1 Yes 2 No 9 Uni	known 9 Unknov	vn		. , , , , _						
or the lache	Part II. Other significant condit	tions contributing to	death but not resul	ting in the un	derlying cause g	given in Part	t I.	23e. Did to	obacco use contrib	oute to the	cause of death?
, P.O. B res that the d signed by the be detached d by Phy								1 Yes	2 No 3	Probably	y 4 🗸 Unknown
ords, w requir s been s should t					_			24a, Was			sy findings available
Sor law r 2 sh	I El I perfo								rior to comp eath?	pletion of cause of	
tal Recting The certificate ector, page								1 Yes	2 No 1	<b>✓</b> Yes	2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death. In the this certificate has been signed by all Director. After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	25. Was case referred to medica examiner?	I I a a sitali.				of Death (C				7	
FVi Physi ral dir To	1 ✓ Yes 2 No			/Outpatient			Nursing H		Residence 6	_	ene
n of ding Ph. After tl funeral	27. Manner of Death		Day,Year)	b. Time of Inj	·	ryatWork?	1	a. Describe i nknown	how injury occurre	.a	
ttend teath tor: / the	Pend	stigation		d 4:00	Pm	Yes 2 X					
Divis  Divis  pital or At ours after d filled in by Certifice		d not be	of Injury - At home			ouilding, etc.	. 28	f. Location (\$ or Town, S	Street and Number State) 9710 B	r or Rural F	Route Number, City <b>ven Ln.</b>
Division o vithin 24 hours after death. To the Funeral Director: After completely filled in by the fune edical Certification:	4 L Homicide	rmined (Specify)	Found: Re	sidenc	e		0	wings	Mills,MD	).	15
D To the Hospital within 24 hours To the Funeral completely filled	(oneon only	hysician: To the best									
To the Hos within 24 h To the Fur completely	one) 2 Medical Exa	miner: On the basis of and manner sta		or investigatio	n, in my opinion	i, death occi	urred at th	e time, date	and place, and du	ie to the ca	iuse(s)
F ? F ° Š	29b. Signature and title of certifie	er A			29c. Licens	e number			29d. Date signe	d (Month,	Day, Year)
	ling	U -	>		O.C.I	M.E.			May 23, 201	12	
	30. Name and address of person	who completed cause	of death (Item 23	a)							
	Ling Li, MD Assista	nt Medical Exam	iner 900 W.	Baltimore	Street, Balt	imore, M	ID 2122	3			
State	31. Date filed (Month, Day Year)	32. keg	istrar's Signature	-					<del>.</del>		
Registrar	10401	2012	wa s.	par							
DHMH 17 Rev 1/2001 OCME 2006		•••	C	RIGINAL				OCME			
JUITIL ZUUU											

Medical Examiner

CARROLL DUNNIGAN

attending physician and for use as the burial-tran been signed by the a should be detached has page 2

IF FEMALE

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

JUSTINE PREIS, CRNP

Physician/

Medical

10a. State

Examiner

**Funeral** 

**Director** 

28a-f show

o

23a

items

"natural"

al Hygiene.

Department of Health and Mental H Important: If item 27 is marked any injury or attack

Physician

notified at

must be

Medical Examiner ō

injury or other traumatic event, the

Director

Funeral

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Completed

Be

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within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Examine /Medical P.O. Division of Vital Records, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific filled in by the funeral director,

To the Hosp within 24 hou To the Fune completely fi State

Physician	in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	Month Day Year
ò		ontributing to death but not resulting in the underlying cause given in Part I.  ———————————————————————————————————	23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 Probably 4 □ Unknown
Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 2 ☐ No
ge	25. Was case referred to medical	26. Place of Death (Check of	only one)
0	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)
rtificate:	27. Manner of Death  Natural 5 Pending  Accident Investigation	(Month, Day, Year) injury work?  M 1 \( \sum Yes 2 \sum No \)	3d. Describe how injury occurred
al Certi	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
Medica	(Check 2 Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred at the se Practitioner: To the best of my knowledge, death occurred at the time, date and place.	he time, date and place, and due to the cause(s) and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Registrar

2300 DULANEY VALLEY ROAD

reis CRINT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## amend 10e, per. fh. g928 6-1-12 sm Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		rtment of I			giene Reg. No 2012	17290
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Ellen D	ancik				2. Date of Dea Month 5/	Day Year	3. Time of Death  11:00am
*	Examir		4a. Facility Name (If not institution, give s Ginger Cove Nurs				or Location of De	ath	4c. County of Dea Anne Aru	
	Funeral Director		000 10 1011	7. Age (In yrs. I.) M 2 12 F 94	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi			thplace (State or Foreign buntry) Slovakia
	aryland ehow	'n	Usual Residence of Decedent  10a. State 10b. County  MD Ann	10c. City	, Town or Lo	cation Annapo	lis			10d. Inside City Limits 1 ☐ Yes 2 No
	with the M s or 28a-f	Director	10e. Street and Number 4000 Ri		r.	10f. Zip Code	21401	1	10g. Citizen of What C	ountry?
036	72 hours after deeth with the Maryland "naturel", or tleme 23s or 28s-f show salical Exactinat must be coulded at	by Funeral		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	li li	Vas Decedent of Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		erican Indian,
21215-0036	d within 72 ho piene. ir then "natur it a Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of w d)	rorking	16b. Kind of Business	
and 2	be filed ital Hygi d other event, t	Be	12 17. Father's Name (First, Middle, Last) Unk •	Kraus	e	Homema	18. Mother's N	ame (First, Middle,		e ttert
Maryland	ges 1 and 2 should it of Health and Men if Item 27 is marks or other treumatic	욘	19a. Informant's Name/Relationship (Ty) Jo Ellen Valentin	pe, Print) le /Daughte	19b. Mailin	g Address <i>(St</i> ree 1509 Shi	and Number or ps View	Ruraj Route Numbe Rd, Annaj	or, City or Town, State, polis MD 21	Zip Code) 409
	Pages 1 and ment of Heali ent: If Item 2 ury or other		20a. Method of Disposition 1728 Burial 2 ☐ Cremation 3 ☐ R		metery, cren	sition (Name of natory or other pla	ce) terv 5/	Date /21/12	20c. Location - City or Ridgew	_
Baltimore,	permit. Page Department Importent: If any njury or		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License						l Home, Inc more MD 212	
760,	Physician / Medical Examiner physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien are physicien and physicien and physicien are physicien and physicien are physicien and physicien are physicien and physicien and physicien are physicien and physicien are physicien and physicien and physicien are physicien and p	Ilcal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sacuentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):					Approximate Interval Between Onset and Dead
P.O. Box 68	res thet the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	у		23d. Date of de Month	livery Day Year
	The faw requii	Completed by Pl	Part II. Other significant conditions con	ntributing to death but not resu	ilting in the ur	nderlying cause gi	ven in Part I.	1 ☐ \	an 24b. Were a prior to med? death?	o the cause of death?  robably 4  Unknown  utopsy findings available completion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: I within 24 hours after death. To the Funerel Director: After this certificel completely filled in by the funeral director, p	Certification; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  1 Natural 5 Pending investigation 3 Suicide 4 Homicide  1 Natural 6 Could not be determined	lospital: 1 tnpatient 2 1 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At ho building, etc. (Specify	ER/Outpatien 28b. Time of Injury me, farm, stre	28c. Inju Wo	her: 4 Nursing	28d. Describe h	dence 6 Other (Spenow injury occurred	
	Hospital of 24 hours af Funerel Detely filled in	Medical Cer	Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinat	wledge, death	occurred at the trestigation, in my	me, date and pla	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2. To the complete	Med	29b. Signature and title of confider	and manner stated.			se number		29d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who co	empleted cause of death (Item		Print)  O A		a lie n	0 1	1-2012 nn Dale MD 20769
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra 's Signa	and	/1	mayo	111	W 4/6	MD 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles John Dorsey 5/30/2012 16:18p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-44-3855 Months (Month, Day, Ye 9/28/46 Director 1**XX**M 2 □ F 65 MD Yrs. Usual Residence of Decede 28a-f show 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Anne Arundel Pasadena 1 Yes 2XXNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 209 Solar Ct 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 1. Marital Status Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 XX Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 salth and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Truck Body Sales Small Business Owner 12 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မ Lloyd George Dorsey Mary Beatrice Hagen 19a. Informant's Name/Relationship (Type, Print)
Dorothy Elizabeth Dorsey/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
209 Solar Court, Pasadena Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) Holy Cross Cemetery 4 Donation 5 Other (Specify) 6/4/2012 Baltimore Maryland of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ocatolial Infarction Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions Due to (bries a nonsequence of): cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last 61802/2011a attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death been signed by the a should be detached 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ oronor 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I performed within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 R/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Neertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and t DO044394 May 30, 2012 person who completed cause of death, (Item 23a), (Type, Print) 8600 old Georgatown Rd. Bethesly, MD 20814

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

12-04055 Richard D'Agostir			e or Print in Bla te of Maryland /	Department of	of Health a			egible.	201	2 1729
Physicia		Registrar  1. Decedent's Name (First, Middle	Last)	Certificate of	or Death		2. Date of D	Reg. No.		3. Time of Death
Medical Examin			d C. D'Agost	cino			Month May 28,	Day	Year	2123 hrs
		4a. Facility Name (if not institution Sinai Hospital	give street and number)		4b. City, Town, o Baltimore	or Location of	Death	4c.	County of Death	
Funeral Director		200 50 4560		(In yrs. last birthday)	If Under 1 Ye		24Hrs. 8. Date of Min.	Birth (MM/D	D/YYYY) 9. Birt Foreig	
Director		220-52-4568 Usual Residence of Decedent	1X M 2 F	)4 <sub>YI</sub>		i,ys Tiodis		19,		aryland
ku a	ŀ	10a. State 10b. County	11	Oc. City, Town or Loca	ation	_				10d. Inside City Limits
Maryland 28a-f show d at once.	۱	Maryland N/A		Ва	ltimore					1 X Yes 2 No
Maryl r 28a-l	Director	10e. Street and Number			10f. Zip Code	_			en of What Coun	try?
ith the 23a or	L	4320 Roland Spi		: II 0	2121				USA	
eath w	Funer	1 Never Married 2 Mar	12. Was Decedent Evried Armed Forces?		as Decedent of H Yes, specify Cuba		? ( Specify Yes or uerto Rican, etc.)	No- 1	4. Race - Amend White, etc.	can Indian, Black,
after d	회	3 Widowed 4 Divo	1 Yes 2 2 Ced If Yes, Give Year or Dates:		Yes 2 N	o specify:		s	ipecify: Whi	te
hours natura		15. Decedent's Education (Speci	y only highest grade compl	- during r	nt's Usual Occup			16b. Ki	nd of Business/Ir	ndustry
1215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. sarked other than "natural", or items 23a or 28a-f sho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Artis	t-			5	Self Emp	loved
5-00 ed witi fygien other	하	17. Father's Name (First, Middle, L		111 618		18.Mother's	Name (First, Middle		-	10,00
121 d be fil ental F arked	8	James S. D'Ago					Ann List			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	의	19a. Informant's Name/Relationshi Pegeen D'Agost:					erorRuralRouteN s Drive F			Zip Code) 21210
Baltimore, I bernit. Pages I and Department of Heall Important: If item njury or other tra		20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal from State	20b. Place of Dispo crematory or o Hilltop	ther place)		Date 5/31/12	- 1	ocation - City or Owson MD	•
it. Pagitment artent	1	4 Donation 5 Other Spe 21. Signature of/Funeral Service L		1						
		Chalte	(ton				Inc. ad Balti			
Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of the control of the cont	each line.							Approximate Interval Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Hypertensiv		clerotic	Cardi	ovascular	Dise	ase	Death
		Sequentially list conditions,	b							
	xaminer	if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated	Due to (or as a consequence.	uence of):						
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Exa	events resulting in death) Last	Due to (or as a consequ	uence of);						
ox 68760, sath certificate be executed attending physician and for use as the burial - transit	an/Medical	X UNPENDED	dAMENDED 23a, 2	27, per me,	g928 6-4	-12 sm	-		<del></del>	
876( ificate ig phys s the b	Š į	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome		etal death 3	Ectopic p	regnancy		Date of delivery	av Year
Box 68760 re death certificate by the attending physi	힐ㅣ	past 12 months?  1 Yes 2 No 9 Unkn	4 Pregnant at tim	e of death	ther (Specify)			"		., 100
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physici page 2 should be detached for use as the built	≦	Part II. Other significant conditio	ns contributing to death b	ut not resulting in the	underlying cause	given in Part I				ne cause of death?
rds, require been si	eted						24a. Wa			opsy findings available
Reco The law cate has	Completed					<del></del>		opsy formed? 2 No	death?	empletion of cause of
cinu: certifi ector,	8	25. Was case referred to medical examiner?	Hospital:			of Death (Ch				
Physical division	٥,	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of		ury at Work?	ursing Home 5 28d. Describ	Residence		
OD ( cading ath. r: Aff		1 Natural 5 Pendin	(Month, Day,Year)	)		Yes 2 N				
Division of Vital Records, P.O. Boy othe Hospital or Attending Physician: The law requires that the dealt within 24 hours after dealth.  The theory after dealth of the first	Certification:	2 Accident Investig 3 Suicide 6 Could of determ	ot be 28e. Place of Injury	y - At home, farm, stre	et, factory, office	building, etc.	28f, Location or Town		Number or Rur	al Route Number, City
e Hospit 124 hour e Funer:		29a. Certifier 1 Certifying Phy	sicisn: To the best of my ki	-				. ,		
Fo th	edica	one) 2 Medicai Exami	ner: On the basis of examin and manner stated.	nation and/or investiga	tion, in my opinio	n, death occur	red at the time, da	e and place	e, and due to the	cause(s)

State Registrar

Pamela E. Southall, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and appress of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 29, 2012

12-03828 Jewel S. Daily		State - For State	or Print in Black of Maryland / De )	partme			Hygiene	201	2 1729
Physician/ Medical Examine	1	egistrar  I. Decedent's Name (First, Middle,Las  Jewel Siobhan I	Jewel S. Da	iley			2. Date of Death	Day Year	3. Time of Death
		la. Facility Name (if not institution, giv Baltimore Washington Me	e street and number)		4b. City, Town, o Glen Burni			4c. County of Death	
Funeral Director		703 37 2313	7. Age (In y	rs. last birth	Months Day	ys Hours M	Min.	1 h(MM/DD/YYYY) 9. Bir Foreig 21, 2012 M	
Maryland 28a-f stow any 1st once.	1	Jsual Residence of Decedent 10a. State 10b. County  Maryland Anne Ar		City, Town o	or Location Sever	n			10d. Inside City Limits 1 Yes 2 No
the Maryland 3a or 28a-f sh ofilied at once		0e. Street and Number  1403 Graham Farm	Circle		10f. Zip Code	144	10	g. Citizen of What Cou United St	
Baltimore, MD 21215-0036  pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	М	1. Marital Status 1. X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 Yes 2 N If Yes, Give Year	0	13. Was Decedent of H If Yes, specify Cuba  1 X Yes 2 No	ispanic Origin? ( n, Mexican, Pue	erto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
5-0036 ed within 72 hours: lygiene. other than "natur: he Medical Exami Completed E	F	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	ly highest grade completed College (1-4 or 5+)		Decedent's Usual Occupa luring most of working life			16b. Kind of Business/I	ndustry
15-003 filed within Hygiene. d other th.		7. Father's Name (First, Middle, Last)		_l	None	18.Mother's Na	me (First, Middle, M	None aiden Surname)	e
2121; ould be fill ould be fill d Mental H s marked lic event,	ŀ	Bryant Dailey, J 9a. Informant's Name/Relationship (T	ype, Print)	19b	. Mailing Address (Stre		y Slade or Rural Route Numb	per. City or Town. State	. Zip Code)
MD d 2 shoilth and a 27 is manatis	L	Carmen Slade/Gran	dmother	14	03 Graham H	arm Cir			
imore, Pages 1 an ment of Hea tant: If iter or other tra		0a. Method of Disposition    X Burial 2 Cremation 3     Donation 5 Other Specify:	Removal from State	Epiph	Disposition (Name of certification of the place) Lany Episcop Lrch Cemeter	al y	May 23, 2012	20c. Location - City or Odenton, Ma	ryland
	1	1. Signature of Funeral Serice Licen	MO MO	1386	1411 Anna	polis K	oad, Uden	Crematory, ton, Maryla	and 21144
Physician /Medical Examiner		3a. Pan I Enter the disease, or comp failure. List the one couse of ea mmediate Cause (Final disease a. or condition resulting in death)			enter the mode of dying	, such as cardia	c or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
ted 1 Insit Examiner	ii co ()	ause. Enter Underlying Cause	Due to (or as a consequence						
execu an and al - tra		X UNPENDED X	AMENDED#1,23a	,27,2	8a-f,per me	,g929 7-	-17-12 sm	<del>.</del>	
box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	23	FEMALE: bb. Was decedent pregnant in the past 12 months?  Yes 2 No 9 Unknown	23c. If yes, outcome of p  1 Live birth  4 Pregnant at time of	2	Fetal death 3 Other (Specify)	Ectopic preg	gnancy	23d. Date of delivery Month D	ay Year
s, P.O. I		art II. Other significant conditions	contributing to death but no	ot resulting	in the underlying cause	given in Part I.		acco use contribute to a	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach ledical Certification: To Be Completed by P							24a. Was ar autopsy perform 1 V Yes 2	prior to coned? death?	opsy findings available ompletion of cause of
Vital ysician his cert directo	1	5. Was case referred to medical examiner?  1 ✓ Yes 2 No	ospital: 1 Inpatient 2	✓ ER/Out	patient 3 DOA	Other Nurs		esidence 6 Other	
ion of tending Pherath.  tor: After to the funeral the funeral ation: T	2	7. Manner of Death 1 Natural 5 Pending 2 X Accident Investigation	28a. Date of Injury (Month, Day, Year)			ry at Work? Yes 2 ★ No		w injury occurred suffocated	in mothers
Division o Within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune edical Certification:		Suicide 6 Could not be determined	28e. Place of Injury - A	t home, fan	m, street, factory, office l	•	28f. Location (Str or Town, Sta	reet and Number or Rur Ite) 726 Dona1 Inde1 Count	dson Ave.
To the Hos within 24 h To the Fur completely	(100	ne) 2 Medicai Examiner	an: To the best of my know On the basis of examinatio and manner stated.	ledge, deat n and/or inv	estigation, in my opinior	n, death occurred	d at the time, date ar	nd place, and due to the	cause(s)
OGME S		9b. Signature and title of confifier			29c. Licens			29d. Date signed <i>(Mon</i>	th, Day, Year)
- Jan	3	D. Name and address of person who of Mary G. Ripple MD Dep	ompleted cause of death (It outy Chief Medical Ex	,	900 W. Baltimore	e Street, Bal	timore, MD 212	223	
State Registrar		1. Date filed (Month, Day, Year)  JUN 0 1 2012	32. Registrar's Sign	ature	Kal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wanth 2012 Medical lity Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death **Examiner** N/Ahivs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday If Under 8. Date of Birth (Month, Day, Year) cial Security Numbe **Funeral** Min 267-25-4124 1 🛚 M 2 □ F Director 07/01/1923 CANADA 88 or items 23a or 28a-f show miner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 □ No BALTIMORE N/A10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 21210 111 HAMLET HILL ROAD, #906 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status or than "natural", or iter the Medical Examiner Armed Forces?
1 X Yes 2 □ No Black, White, etc 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify. If Yes, Give WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) PHYSICIAN MEDICINE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ WOLSEY GOLDIE DANOFF other traumatic SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is r any injury or other traumonce. 111 HAMLET HILL ROAD, #906, BALTIMORE, MD NANCY DANOFF/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State 05/30/2012 REISTERSTOWN, MD 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM 22. Name and Address of Facility Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final wholevebra Ph, sician/ resulting in death) Medical **Examiner** Mercusio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or Exami eral Director; After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) examiner's Hospital Other: Inpatient 2 ER/Outpatient 3 DOA မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Medical Certificate: Natural 5 Pending injury Division 2 🗌 No 2 Accident Investigation within 24 hours after death To the Funeral Director; 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Notes Practitioner. To the cause of my investigation of the form of the form of the cause of the first order and cause of the first order and cause of the first order and cause of the first order and cause of the first order and cause of the first order and cause of the first order and cause of the first order and cause of the first order and cause of the first order and cause or the (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Onheans Street Baltimore Maryhand 21387 tephanie 1800 na 31. Date filed (Month. ay, Year 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

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		,	_ State	State of Ma	arylan					lental Hy			2	1 -	1295
			Registrar  1. Decedent's Name (First, Middle, Last)	_		Cer	tificate o	r Deal	tn	2. Date of De		.201		2 Time	of Death
П	Physicia Medic		Herbert A. Frankel							Month 5	2	ı 1 201	2	7:00	
-	Examir		4a. Facility Name (if not institution, give stre	,			4b. City, Town				40	. County of De			
49.			10237 Green Holly  5. Social Security Number 6. Sex		An uro In	st birthday)	Si If Under 1 Ye		Sprin		41-	Montgo			
	Funeral Director			M 2 □ F   89		Yrs.	Months Day			8. Date of Bir (Month, Da 2-28-1	ay, Year)	1 '	Jountry	y) York	e or Foreign
	and show	Į.	10a. State 10b. County			, Town or Loc							10	d. Inside	City Limits
	Maryl 28a-f otifie	Director	MD Montgomer	У	Sil	ver Sp	ring							1 🗓 Y	∕es 2 □ No
	ith the 3a or it be n	ralD	10e. Street and Number	m			10f. Zip Cod					itizen of What			
	ems 2	Funeral	10237 Green Holly  11. Marital Status 12	. Was Decedent E	ver in U.S	. 13. V	2081 Vas Decedent o		c Origin? (Spe	cifv Yes or No-		ited St			
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 1  If Yes, Give Year or Dates.	NoWWI	T If	Yes, specify Co	uban, Me	xican, Puerto	Rican, etc.)		Black, Wi		c.	
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altimore, Maryland 21215-0036	tal Hygind other	To Be	17. Father's Name (First, Middle, Last)	<del></del>			<u> </u>	18. N	/lother's Name	e (First, Middle,	Maiden	Surname)	-		
ıryla	should be file and Mental I is marked of raumatic eve		Joseph Frankel  19a. Informant's Name/Relationship (Type,	Print	_	405 14.75			y Good		0:	T 0			
Ma	and 2 shu Health ar tem 27 is		Glenn Frankel - So	*			g Address (Stre 24th Rd						,	đe)	
ore,	e 1 an t of He If item or othe		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Real	noval from State	20b. Pl	ace of Dispos	sition (Name of natory or other p	olace)	[	Date	20c. L	ocation - City	or Tow	n, State	
Iţim	it. Pag rtment rtant: njury o		4 Donation 5 Other (Specify)				Cremato		5-25	_		ls Chur			
Ba	permit Depar Impor any ir once.		21. Signature of Funeral Service Ligensee	Kurt B1	.ake		Name and Add								
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	p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):									
	ecuter and al-trans	Exan	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a	conseque	ence of):							+		
260	icate be executed physician and is the burial-transit	edical	d.												
3876	rtificate ing ph		IF FEMALE:							-					
Division of Vital Records, P.O. Box 687	requires that the death certific.  been signed by the attending p.  should be detached for use as.	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown	If yes, outcome of Live Birth 24 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregna Other (specify)				1	23d. Date of o Month		/ lay	Year
Ö.	hat the ed by t detach	y Ph	Part II. Other significant conditions contri	outing to death bu	ıt not resu	Ilting in the ur	nderlying cause	given in F	Part I.	23e. Did to	obacco ı	use contribute	to the	cause of	death?
ds, I	quires t en sign ould be	ed by								1 🗆	Yes 2	□ No 3 □	Proba	bly 4 Ū	X Unknown
COL	law rec has bee	Completed								24a. Was autoj	psy		o com		s available f cause of
E E	rsician: The law is certificate has the director, page 2 s		25. Was case referred to medical							1 Yes	rmed? 2 X N	death		□ No	
Vita	ysicia is certi directe	To Be	examiner?  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)  Hos	oital:	nt 2 $\square$ £	ER/Outpatient	10	thar	Death (Check	only one) me 5 🛚 Resid	dence 6	Other (Sn	noifu)		
on of	Attending Physer death. ector: After this by the funeral di	Certificate: 1	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day,	/ /:	28b. Time of injury	28c. Inj		2	8d. Describe h			scily)		
Divisi	ial or Atte is after de al Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At hon (Specify)	ne, farm, stre	et, factory, offic	е	1	28f. Location (S City or Tox			Rural R	oute Nun	nber,
)	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	29a. Certifier (Check Check only one) 3 Certifying Physicia 2 Medical Examiner: 3 Certifying Nurse Pr	On the basis of exa	amination.	and/or investi-	gation, in my on	inion deat	th occurred at	the time, date a	and place	and due to th	e calle	e(s) and m	nanner stated.
	To t To t		29b. Signature and title of certifier				29c. Lices		er		29d. Da	te signed (Moi			
	1940		30. Name and address of person who comp				int)								<u> </u>
	1 0		Geoffrey Coleman, 31. Date filed (Month, Day, Year)					ckvi	lle, M	aryland	1 20	850 ———			
	Stat Registra		JUN 0 1 2012	32 egistrar	s Signatu	1. pa	No.								

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De	partment of tertificate of t		Mental Hy	giene 201	2 17296
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of t	Jean	2. Date of De	Reg. No. C 0	
	Physicia		Frederick J. Forrest			Month	30, Day Yea	3. Time of Death 4:15 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, o	r Location of Deat		4c. County of De	
			4903 Battery Lane #3	Bethes			Montgon	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth 9. E	Birthplace (State or Foreign
	Director		110-18-7979	monate Days	Prodre Tviiri.	July 10	y, Year 1926 N	lew York
	ind show at	٦	10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	Aaryla 8a-f s tified	<b>Funeral Director</b>	Maryland Montgomery Bethes	da				1 ☐ Yes 2 🛣 No
	the N	٥	10e. Street and Number	10f. Zip Code			10g. Citizen of What	Country?
	is 23a	Jera	4903 Battery Lane #3	20814			United	States
	death item ner n	F	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puert	pecify Yes or No-	14. Race - Ar	nerican Indian,
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	d by	1 IXI Yes 2 INO If Yes, Give	1 ☐ Yes 2 🛣 No			Black, Wh Specify:	White
Ö	hours natura ical E	Completed	15. Decedent's Education 16a Dec	cedent's Usual Occup	ation		16b. Kind of Busines	
215	n 72   e. ian "r Med	dmo	(Specify only highest grade completed) (Gi	e kind of work done of DO NOT use retired)	during most of wor	king	Tob. Kind of Busines	ss industry
7	withi	ပိ	4	Owner			Upho1st	ery
nd	should be filed wand Mental Hyg r is marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last)				Maiden Surname)	
2	uld bu d Mer marke natic	_	Leo Friedman			Rabinowi		
Ma	2 sho th and 27 is u	1					er, City or Town, State, I	
ē,	f Health Item 27 other tra			position (Name of	i l	Date	20c. Location - City	
0 E	Page 1 nent of ant: If it		1 Burial 2 X Cremation 3 Removal from State cemetery, co	rematory or other place y <b>Crematoriu</b>	· ! Jun	e Î,	· ·	Maryland
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.							
m	B E E		William a. Tonstrey M01173	Obert A. Pu 7557 Wiscons:	mphrey Fun in Avenue,	eral Home Bethesda	, Bethesda-Ci , Maryland 2	nevy Chase, Inc. 0814
			23a. Part 1. Enter the disease, or compile ations that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
-	h sician/		Immediate Cause (Final disease or condition Severe Asthma					Onset and Death
	Medical Examiner		resulting in death)  Due to (or as a consequence of):					
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9/89	certificate nding physuse as the	Med	IF FEMALE:					
S X	tendir r use	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	☐ Ectopic pregnance	:V		23d. Date of d	lelivery
Box	the atter	sic	1	Other (specify)			Month	Day Year
j.	that the ned by tl e detach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ren in Part I.	23a Did to	obacco use contribute	to the cause of death?
	ires the signer of be of	d by		, , ,				Probably 4 Unknown
0	requires been sign should be	lete				24a. Was		utopsy findings available
Records,	he law te has age 2	Completed		<del></del> ,		autor perfo	osy prior to	completion of cause of
<u>a</u>	an: T rtifica tor, p	BeC	25. Was case referred to medical	26. Pla	ace of Death (Chec		2 No 1 LY	es 2 No
N Ta	nysici nis cel direc	일	examiner? 1	Otho	ar.		dence 6 Other (Spe	ecify)
0	ing Pt		27. Manner of Death  1 🔀 Natural 5 🗌 Pending (Month, Day, Year) 28b. Time injury	of 28c. Injury work	at		now injury occurred	
loi	ttendi death tor: A the fi	Certificate:	2 Accident Investigation	M 1 🗆	Yes 2 ☐ No			
DIVISION	or Al after Direc in by	Ser	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
_	spita hours neral i filled	edical	29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death	occured at the time.	date and place, a	nd due to the ca	use(s) and manner as s	tated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	(Check 2 Medical Examiner: On the basis of examination and/or invo	estigation, in my opinio	<ul> <li>n. death occurred a</li> </ul>	at the time date a	ind place, and due to the	cause(s) and manner stated
	North With Control	-	29b. Signature and title of certifier	29c. License			29d. Date signed (Mon	
	1		Mar Mandanin Mysicia	n VC	106817	1	Man 3	1,20/2
	04 1		30. Nameland address of person who completed cause of death (Item 23a) (Type				• • •	
	V		Steven P. Marshak, M.D. 9900 Belwar 31. Date filed (Month, Day, Year)		Dr., Sui	te 325,	Rockville,	MD 20850
	Stat Registra	G	31. Date filed (Month, Day, Year)  JUN 0 1 2012  32. Registrar's Signatus					
			0011 0 = === /0011 / //					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARTHA Year 1920 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 KF Director 190-26-7898 01/3071934 78 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Fallston 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2102 Round Hill Rd 21047 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Š 1 Never Married 2 Married Black, White, etc. 1 Yes 2 X No Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Kenneth Lucas Helen Martha Parson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Fink - Son 9123 Naygall Rd., Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gardens of Faith 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/01/2012 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Ph. 1. Ent.r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumonio Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 687 IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Box ( 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 Vital Hospital or Attending Physician: the funeral director, B B 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Tes 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 24 hours after death Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I only one

Registrar

State

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Mood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death Physician/ Month ANNINFR CHKRO 1015 AM 5 25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mandrin Inpatient Care Center Harwood Anne Arundel Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 214-46-6633 1 **X** M 2 □ F 20-49 Usual Residence of Decedent Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 659 Chapelview Drive 21113 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Bace - American Indian Armed Forces' Black, White, etc. 1 Never Married 2 X Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced If Yes, Give "natural", Year or Dates White injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Stroehmann 12 Supervisor Bread Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annabelle Alice Ammann Richard Ryan Gardiner 1 and 2 should both the Health and Meinten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Linda A. Gardiner</u> / Wife 659 Chapelview Drive Odenton, Maryland 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) June 1, 2012 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery Cheltenham, Maryland Signature of Furgeral Service 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ HROMIC 13 STRUCTIVE ULMONAN cars disease or condition resulting in death) Medical Due to (or as a consequence of) Disease Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of. Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 2 No signed by the a Id be detached f g 🔲 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ᇛ Other: M-1-C-C. 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending iours after death.

Ieral Director: After fulled in by the fulled in the fulled for the fulled in th Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0036581 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2140 Defense tuna 32. Registrar's State Registrar

DHMH 17 Rev 06-2011

		Please Type or Print in Bl	lack Indelible Ink.  / Department of He		
		1 - State Registrar	Certificate of De	ath	giene 2012 17299 Reg. No.
Physic Med		Decedent's Name (First, Middle, Last)     MICHAEL C. GALLION		2. Date of Dea Month MAY	ath Day Year 3. Time of Death
Exam	iner	4a. Facility Name (if not institution, give street and number) FRANKLIN SQUARE HOSPITAL	4b. City, Town, or Lo		4c. County of Death  BALTIMORE
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year	f Under 24 Hrs. 8. Date of Birt Hours Min. (Month, Day	h 9. Birthplace (State or Foreign
Directo ≥		Usual Residence of Decedent	Yrs.	JULY 1	5,1986 CALIFORNIA
aryland a-f sho iied at	Director	MD. BALTO.	Town or Location  PARKVILLE	,	10d. Inside City Limits 1 ☐ Yes 2 <b>X</b> No
the Ma a or 28			10f. Zip Code		10g. Citizen of What Country?
ath with ms 23a must I	Funeral	8 MONHEGAN COURT  11 Marital Status 12. Was Decedent Ever in U.S.	212	234 anic Origin? (Specify Yes or No-	USA
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Section 1 No	If Yes, specify Cuban,	Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	on ing most of working	16b. Kind of Business/Industry
d withir dygiene that the	Be Co		N/A		N/A
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth	To B	17. Father's Name (First, Middle, Last)  FRED GALLION		8. Mother's Name (First, Middle, VIDIA CRUZ	·
Mai 12 shor aith and 27 is n		19a. Informant's Name/Relationship (Type, Print)  FRED GALLION  FATHER	19b. Mailing Address (Street and 8 MONHEGAN CO		r, City or Town, State, Zip Code) <b>E, MD.</b> 21234
Baltimore, bermit. Page 1 and Department of Her Important: If item any injury or othe		20a. Method of Disposition 20b. Place	ce of Disposition (Name of netery, crematory or other place)	Date	20c. Location - City or Town, State
Iltim nit. Pag artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of ☐ Haral Service Licensee	RKWOOD CEMETERS  22. Name and Address of		PARKVILLE, MD.  FUNERAL HOME, INC.
Ball permir Depar Impol		ma fund	9705 BELAIR	ROAD NOTTING	HAM, MD. 21236
Phylician Medica		23a. Part 1. Enter the disease, or complications that cause the death. I shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	ONS OF CER		Onset and Death
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Division of Vital Records, P.O. Box 68760 fo the Hospital or Attending Physician: The law requires that the death certificate builthin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the temperature.	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
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Physic Physic r this co	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER  27. Manner of Death 28a. Date of injury 28	R/Outpatient 3 DOA Other:  Bb. Time of 28c. Injury at	4 Nursing Home 5 Resid	lence 6 Other (Specify)
on C ending eath. or: Afte	Certificate:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury work?	s 2 🗆 No	,,
Division of Vital Records, tal or Attending Physician: The law requires is after death.  In Director. After this certificate has been signed in by the funeral director, page 2 should be in by the funeral director, page 2 should be a s		3  Suicide 6  Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)
Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledd 2 Medical Examiner: On the basis of examination are 3 Certifying Nurse Practitioner: To the best of my knowledd 2 Certifying Nurse Practitioner: To the best of my knowledd 2 Certifying Nurse Practitioner: To the best of my knowledd 2 Certifying Nurse Practitioner: To the best of my knowledd 2 Certifying Nurse Practitioner: To the best of my knowledd 2 Certifying Physician: To th	nd/or investigation, in my opinion,	death occurred at the time, date a	nd place, and due to the cause(s) and manner stated.
To the		29b. Signature and title of certifier M	29c. License ni		29d. Date signed ( <i>Mpnth</i> , <i>Day</i> , <i>Year</i> )
		30. Name and address of person who completed cause of death (Item 23	Del /Torre Deleth		2005 MD -2/220
St	ate	DAVID YIP MD. 9000 FRANKE 31. Date filed (Month, Day Year)  32. Registrar's Signature  32. Registrar's Signature	LIN SQUARE 1	DALTIN	NORE, MD. 21237
Regis		JUNUIZUIZ Kenna J. Ball	- Contract of the contract of		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-04071 State of Maryland / Department of Health and Mental Hygiene Cody Thomas Green 2012 17300 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 29, 2012 1232 hrs Medical Examiner Cody Thomas Green 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Baltimore City University Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Hours 06/09/1993 18 Director 215-39-8815 Country) 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 X No Harford Jarrettsville MD items 23a or 28a-f show ust be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho rector 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21084 ö 2316 Northcliff Drive 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes White 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify: 3 Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Construction Recycling Laborer 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wendy Rose Wieciech (Golebieski) Randy Allan Green Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 8 2316 Northcliff Dr., Jarrettsville, MD 21084 Wendy Weiciech - Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 06/02/12 Baltimore, MD permit. Page Department o Holly Hill 4 Donation 5 Other Specify: 22. Name and Address of Facility Schimunek Funeral Home 21 Signature of Funeral Service Licensee 610 W. MacPhail Rd., Bel Air, MD 21014 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death <sub>a.</sub> Asphyxia Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): b. Hanging Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical AMENDED physician the burial -UNPENDED Box 68760. 23c. If yes, outcome of pregnancy 23d Date of delivery IE EEMALE: 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Š 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? After this certificate has Yes 2 No 1 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital æ Other Nursing Home 5 Residence 6 Other: Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ 1 Yes 2 28a. Date of Injury (Month, Day, Year) FOUND: 28c, Injury at Work? 28d Describe how injury occurred 28b. Time of Injury 27. Manner of Death Subject found hanging Certification: within 24 hours after deau.

To the Funeral Director: A FOLIND 1 Natural 1 Yes 2 ✔ No Pendina May 27, 2012 2236 hrs Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 2316 Northcliff Drive, Jarrettsville, MD (Specify) Single Family Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

State Registrar DHMH 17 Rev 1/2001

29c. License number

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

and manner stated

32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ana Rubio M.D., Ph. D.

29d. Date signed (Month, Day, Year)

May 30, 2012

			For	State of Ma		d / Depa	ırtmen	t of H	lealth :				_	ible.		0.01
			State Registrar  1. Decedent's Name (First, Middle, Last,			Cer	tificate	of D	eath		2. Date of De	Reg. No	<u>. 2 U</u>	12		<u> </u>
	Physicia		Jerome Georgie								Month 05	25	ay 20	) 1 2	3. Time of D	
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,	<u>لمر</u>		1121 Darley Ave		An um Inc	st birthday)	Ba If Under		more If Under		8. Date of Bir	<u> </u>	N/Z		lace (Cénés	Familia.
	Funeral Director		217-40-2551	M 2 □ F			Months	Days	Hours	Min.	6. Date of Bir (Month, Da 11/20	y, Year)	42	Count	lace (State or : ry) 7land	Foreign
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5	ing Ph (ftar th unaral	ate:	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of injui (Month, Day	rv :	28b. Time of injury	2	8c. Injury work	at ?	28	3d. Describe I		-		4510	ENCE
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129	To the Hospital or Attending Physician: Tha lew within 24 hours aftar death. To the Funeral Director: Aftar this cartificata has complately filled in by the funeral director, page 2	Medical	(Check 2 Medical Examin	ician: To the best of ner: On the basis of ea e Practitioner: To the	xamination	and/or invest	igation, in	my opinio	n, death o	ccurred at t	he time, date a	and place	e, and due	to the cau	se(s) and mani	ner stated.
#	7 × 4 × 10 × 10 × 10 × 10 × 10 × 10 × 10		29b. Signature and title of certifier	0 4 4	10	-	290	License	number	017		29d. Da	ate signed	(Month, E	Day, Year)	
			30. Name and address of person who co	ompleted cause of de	eath (Item	23a) (Tvne P	rint)	K1º	17/	76						
6			JACKIE JONES	CRNP Z	300	Duy	ANE	IV	ALLE	YR	DIV	100	14	1, Mi	240	193
/	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 1 20.		ar's Signatu	B. p.	eska									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 22, 5:05 P 2012 Gosler Veronica Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 618 Linnard Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Director 1 M 2 X F 218-16-2267 88 Yrs Maryland March 18,1924 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 U.S.A. 618 Linnard Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Catholic Charities N/A Comptroller Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Wharry Conrad Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 Jacobia Drive Pasadena, Maryland 21122 Shirley L. Wagner (Sister-in-law) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Most Holy Redeemer 05/30/2012 Baltimore, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland . Signature of Funeral Service Licensee MOD-732 1 21122 23a. Pa. . Enter the disease, or complications that caused the death. stock, or heart failure. List only one cause on each liny. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami Cause (Disease or injury The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 1 Yes 2 9 Unknown Ó 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 L o 3 ☐ Probably 4 ☐ Unknown Records, 1 Tes 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗹 No 1 📮 Yes Hospital or Attending Physician: Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 2 No Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this ð 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛮 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation
6 Could not be determined Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ SRACE ARR Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Pickersqill Retirement Community Towson Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Ye Days 1 M 2 XF Months 226-09-9133 96 Director 1916 Usual Besidence of Decedent should be filed within 72 hours and and Mental Hygiene.
I show marked other than "natural", or items 23a or 28a-f show it marked other than "natural", or items 23a or 28a-f show are went, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Monkton Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 1743 Monkton Farms Drive 21111 of America 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify white Completed 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Bendix Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Emanuel Albin Agnes V. Perry traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 1743 Monkton Farms Drive Monkton, Maryland 21111 Mrs. Joan Ruggles/ daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June date , 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Dulaney\_Valley Memorial Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Gardéns 21. Signaty Fyneral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. once Timonium, Maryland 21093 2325 Yordk Road 23a. art 1. El ter the disease, or complications that caused till? reath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death, Immediate Cause (Final Physician/ ACUTE MYOCARDIAL INFARCTION disease or condition TOUR Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) death certificate be executed Exam resulting in death) Last attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 mont Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the sign of the sign 23e. Did tobacco use contribute to the cause of death? þ DOMONTIA Records, 2-No 3 ☐ Probably 4 ☐ Unknown should ! Completed 1 Yes CHRUNIC PENAL PAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performed page ANEMIA certificate 1 Yes 2 No 25. Was case referred to medica Division of Vital director, Be 26. Place of Death (Check only one) examiner? Hospital 2 1-1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred Hospital or Attending 1-Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, after determined To the Hospital or within 24 hours aft To the Funeral Dis completed filled in Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowled at the fine date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date lled (Month, Da State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30<sup>Day</sup> May Month 2012 1:37 P. M Gloria Mav Medical Harryman 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1801 Rollins Court Bel Air Harford 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2XX Nov. 127 Year 1926 Mary Tand 85 Director 220-22-8704 Usual Residence of Decedent 28a-f show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1801 Rollins Court 21014 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Rlack. White, etc. 1 Never Married 2 X Married þ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alburn Gordon Raynes Edna B. Miller .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George Harryman, III/Spouse 1801 Rollins Court Bel Air, Maryland 21014 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Dongtion 5 ☐ Other (Specify) Evans Funeral other asset Forest Hill, Maryland Air 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral CHapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one dayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Jor disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 \( \sum \) Yes 2 \( \sum \) No 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A Accident Investigation the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only d 29b. Signature and title of certifier May 31, 2012 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
MyO Min (M. W.) 510 Upper Chusapeake Drive #409 MD 21014 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 26, per Phy, 9928 6-1-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4a. Facility Name (if not institution, give street and number) 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖫 F Months Days Min. 217-22.945 9 Hours Mari Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ✓ Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral mi 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes Give Specify 3 Widowed 4 Divorced Completed a Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO, NQT use retired) (Seconday (0-12) College (1-4 or 5+) Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Λ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - Lity or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MDQIQ16 21. Signature of Fineral Service Licensee 53 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final CORONARY ARTERY DUSCASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician ? Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death the detached Unknown been signed by t should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 | No 1 performed within 24 hours after death.

To the Funeral Director: After this certificate it 1 Yes Yes director, 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Hospital 1 Yes Other: 2 X No ဂ္ 3 🗌 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 apleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide injury 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title who completed cause of death (Item 23a) (Type, Print) 223. GREENE BOUGLAS 31. Date filed (Month, Day, 32, Registrar's Signatur State JUN 0 1 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 May 29 <u>Walter J. Herchowski, Jr.</u> 7:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12000 Tralee Road Timonium Baltimore . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 217-26-4074 Months Days Hours Min **Director** 1 X M 2 🗆 F Mary land 3 1922 Usual Residence of Decede show 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f Mary land Baltimore Timonium 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code "natural", or items 23a or 10g. Citizen of What Country? Funeral U.S.A. 12000 Tralee Road #502 21093 Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married X Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owner Bakery event, Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot rother traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Herchowski, Sr. Ida Bielski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Elliott / Daughter of Health 2903 Franklins Chance Drive Fallston, Maryland 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. 1 Burial 2 Cremation 3 Removal from S 4 Donation 5 X Other (Special) Comment DulaneyValleyMem.Gdns 6/1/2012 Timonium, Maryland 21. Signature of Fundament e 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or cornel ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ancreatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (bisease or Injury Due to (or as a consequence of): g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law has autopsy performed prior to completion of cause of death?

1 Yes 2 No certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at illed in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [

Registrar

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who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HEOTIS 0933AM HALL MAY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Director 479-40-4456 1 🛛 M 2 🗆 F May 6, 1939 73 Iowa Usual Residence of Dece 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No N. Potomac MD Montgomery 10e. Street and Numbe 10g. Citizen of What Country? 23a or Funeral United States 20878 11724 Silent Valley Lane or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. African Armed Forces? <u>م</u> X Yes 2 No (unk) 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", If Yes, Give 3 Divorced 4 Divorced Completed American Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Information Technology 4 Private Contractor marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Othello Brewer Theotis\_ W. Hall, Sr. and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health i 11724 Silent Valley Ln. North Potomac, MD 20878 Joan W. Currin-Hall / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 Department of Important: If it any Injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State Flinal Journey Crematory5/31/2012 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland ature of Funeral Service Lio Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death ARRHYTHMIA Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and I-transit Examil that initiated events resulting in death) Last Due to (or as a consequence of): physician ar s the burial-1 Physician/Medical The law requires that the death certificate be Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Division of Vital Records, P.O. by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate I Yes 2 X No 1 🗆 Yes 2 🗆 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 💢 No Other: 1 Inpatient 2 NER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ Funeral Director: After this etely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN D0063941 npleted cause of death (Item 23a) (Type, Print) MEDICAL CENTER DRIVE ROCKVILLE MARKENDO LENORA, MD 9901

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 28 2012 9:15 Floyd Hultslander, AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sunrise - 502 Logan Street Frederick Frederick Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. (Month, Day, Year) Director 071-18-7874 1 **X** M 2 □ F Dec 28, 1924 87 New York or 28a-f show e notified at 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No MD Frederick Frederick 0 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? pe "natural", or items 23a Funeral 502 Logan Street 21701 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1X Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 X Widowed 4 Divorced Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Delilah Brink Floyd Hultslander, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Hultslander / Son 502 Logan St. Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/1/2012 Final Journey Crematory Woodbine, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death ep515 Physician/ disease or condition resulting in death) 0/175 Medical Due to (or as a consequence of) Examiner 1565TAUCTTO~ Small Bowe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate being a hours after death.
Funeral Director: After this certificate has been signed by the attending physicia. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Pregnant at time of death Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completely filled in by the funeral director, page 2 After this certificate has autopsy performed? 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 06-2011

(Check

only one)

3 🗌

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RANK

MO

180

32. Registrar's Signature

29b. Signature and title of certifie

31. Date filed (Month. Day, Year

29c. License number

Tohnlow

D0075152

29d. Date signed (Month, Day, Year)

2,702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 4:45 AM Mary Horvath-Kirk May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Lorien Nursing Center Columbia Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 236-54-9931 **Director** Jan 10. 1935 West Virginia 77 Usual Residence of Deced iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location Director 1 Yes 2 X No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6334 Cedar Lane 21044 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1 Never Married 2 Married 2X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 27 is marked other than "r traumatic event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Worker Manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Albert B. Margaret C. Noshagy traumatic Dudash Department of Health and Important: If item 27 is n any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Irene Veazey / Daughter</u> 7714 West Shore Road Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Journey Crematory 5/31/2012 4 ☐ Donation 5 ☐ Other (Specify) Final Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 of Funeral Service Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicsan/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No igned by the atte be detached for Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dabetes mellitu 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Rectal Cancer autopsy certificate has Bipolar Disease 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) under 2 No s after death.

I Director: After this or ed in by the funeral dire 1 Yes hospice မ 1 Inpatient 2 I ER/Outpatient 3 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined To the Hospital within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 LANE EPAR OLUMBIA

DHMH 17 Rev 06-2011

State Registrar IDSEPH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ 2012 2:00 Рм Hillman Jeanette Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Carriage Hill Nursing Home Bethesda If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Country) Kentucky Months Days Hours Min 7-29-1917 94 Director 215-09-6531 Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland 10a. State Director 1 XYes 2 No Silver Spring MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 20906 15115 Interlachen Drive #717 United States Examiner must items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White 3 X Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Pauline Kramer Louis Siegel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Tower Road, Villanova, PA 19085 Jennifer Hahn - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State King David Mem. Gdns. 5-30-2012 Falls Church, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction Signature of Funeral Service Licenses Ed Sage1 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Priysician Dysphagia Medical resulting in death) Due to (or as a consequence of): Examiner Cerebral Vascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ᅙ Due to (of as a consequence oi). Exami Hypertension that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires Dementia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an sate has page 2 s prior to completion of cause of death? performed? Yes 2 X No this certificate 1 Yes 2 No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and itle of cert 29c. License number D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan Miller,

100

31. Date filed (Month, Day, Year,

JUN 0 1 2012

DHMH 17 Rev 7/2009

Registrar

8218 Wisconsin Avenue, Ste #305, Bethesda, Maryland 20814

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

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		4a. Facility Name (if not institution, give					cation of Death		4c. County of D	
		St. Agnes Hospital				imore		1	N/A	
Funeral	1	5. Social Security Number 6. Sex	7. Age (In y	rs. last birth	day) If Ur Mor		If Under 24Hrs. Hours Min.	1		Birthplace (State or Foreign Country)
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Aaryland 28a-f show i at once.	힑	10 IN / F			10f.	Zip Code	TIHOTE	100	. Citizen of What	: Country?
th the Maryland 23a or 28a-f sho notified at once.	Director	603 N. Chapel I	ane Ant 1	0.2		21229	)		U.S.	Δ
ith th			12. Was Decedent Ever		13. Was Dece	dent of Hispar	nic Origin? ( Spe	ecify Yes or No-	14. Race - /	American Indian, Black,
eath w items		1 X Never Married 2 Married	Armed Forces?	No.	If Yes, spe	ecify Cuban, M	lexican, Puerto I	Rican, etc.)	White,	
fter de l'', or		3 Widowed 4 Divorced	Yes, Give Year or Dates:			2 X No 5				Black
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than it event, the Media	To Be	19a. Informant's Name/Relationship (Ty	oe, Print )	19b	. Mailing Addr					State, Zip Cod
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	Edna Gladney (	randmothe	er) 6	03 N.	Chape	el Lane	Apt_	102, B	alto., MD
e, Nad I and Health	ı	20a. Method of Disposition	1.	ZUD. Place U	f Disposition (I	Value of Cerric	tery,	Date	20c. Location - C	lity or Town, State
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Baltimore, permit. Pages I ar Department of Hee Important: If ite	ŀ	21 Sign ture of Funeral Service Licens			JOSE F	Address of	f Bribwn	Jr. Fu	neral	Home PA re, MD21217
<b>9</b> 2 2 1 1	- 1	Jacqueline &	. Xoan	2	2140	N. Fu	ilton I	Ave., B	altimo:	re, MD21217
Physician	4	28a. Part I. Inter the disease, or complifailure. List only one cause on each	cations that caused the o h line.	death. Do no	t enter the mo	de of dying, su	ich as cardiac o	r respiratory arre	St, Shock, or flear	Between Onset and Death
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		or condition resulting in death)	ue to (or as a conseque	nce of):						
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	틾	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a conseque	nea of):						
ed nsit	Exa	events resulting in death) Last d.	ue to (or as a conseque	rice or).						
30x 68760, death certificate be executed to attending physician and if for use as the burial - transit	Medical Examiner	UNPENDED	AMENDED							
60, ate be hysicii e burii	Ned	IF FEMALE:	23c. If yes, outcome of	f pregnancy					23d. Date of c	
587 srtifice ling p	an/I	23b. Was decedent pregnant in the past 12 months?	1 Live birth	af dooth			Ectopic pregna	ancy	Month	Day Year
Box 687 e death certifice the attending p	sici	1 Yes 2 No 9 V Unknown	4 Pregnant at time 9 Unknown	or death (	Other (	Specify)			1	
, P.O. Box 6876  ires that the death certifica  signed by the attending ph  the detached for use as the	Physician/	Part II. Other significant conditions	contributing to death but	t not resultin	g in the underl	ying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
P.C s that gned l	ģ							1 Yes	2 No 3	Probably 4 V Unknown
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Records, F The law requires cate has been sign	Completed	() <del></del>			<del> </del>	<del> </del>		perfor	med? de	eath? ✓ Yes 2 No
Division of Vital Records, P.O. It to the Hospital or Attending Physician: The law requires that the within 24 hours affer death. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		25. Was case referred to medical				26 Place o	of Death (Check			
Vital Pysician: ysician: his certifi director,	Be	examiner?	ospital: 1 Inpatient	2 🗸 ER/0	utpatient 3	DOA	Other Nursi	ng Home 5	Residence 6	Other:
1 of V ding Phy L. After th funeral d	 7	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b.	Time of Injury	28c. Injury	at Work?	28d. Describe t Unknown	now injury occurre	ed .
ion (tending eath. tor: Au	tion	1 Natural 5 Pending	FOUND: Day, Year) May 20, 2012	UNI	KNOWN	1 Ye	es 2 🗸 No	l		
/iSi rr Att ter de irrecte in by t	fica	2 Accident Investigation 3 Suicide 6 ✓ Could not	28e Place of Injury	- At home, f	arm, street, fac	ctory, office bu	ilding, etc.	or Town, S	itate)	er or Rural Route Number, City
Divisi pital or Att curs after d eral Direct	Certification:	4 Homicide determined	(Specify) Resid					1937 Mulberry	Street, Baltim	
Hosp 24 hc Fun etely		29a. Certifier 1 Certifying Physici	an: To the best of my kn	nowledge, de	ath occurred a	at the time, dat	te and place, and	d due to the caus	se(s) and manner and place, and d	as stated. ue to the cause(s)
Divisior To the Hospital or Attend within 24 hours after dear To the Funeral Director: completely filled in by the	Medical		On the basis of examina and manner stated.	ation and/or	vestigation,	29c. License				ed (Month, Day, Year)
	Σ	29b. Signature and title of certifier	(0,0,0)			O.C.N			May 20, 20	•
		Carol 14	allan			Ų.C.N				
		30. Name and address of person who Carol H. Allan, MD Ass	completed cause of deat stant Medical Exar	n (Item 23a) miner 9	00 W. Balt	more Stree	et, Baltimore	e, MD 21223		
	20.60	at D t Clark W Day Vord	37 Registrar's							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:59 P M Lauren A. Kruzinski 2012 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gildrist Center Towson 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 221-70-5065 Hours Director 1 M 2X F 26 11,1985 Wilmington, Oct. Usual Residence of Deced works 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 21 Cedar Chip Court 21234 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 9 þ 1 XNever Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation
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Chapel – Bel Air Date 06, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State June Evans Fi Chapel-Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 2 a. Pa t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. In me nate Cause (Final Onset and Death Physician/ rodular NOSUNG di sea e or condition COVS Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last burialat ending physician Physician/Medical that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year by the Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ requires Records, 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform this certificate 2 🗌 No Yes Yes 2 Division of Vital • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation completely filled in by the Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

State

the

Medical

29a. Certifie

29b.

(Check

only one

Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aistrar's Signatui

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

N. Charles

29d. Date signed (Month, Day, Year)

012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2.4 2012 10:00 AM Sylvia Kaye Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Hebrew Home Of Greater Washington If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Yea Davs Hours 1 M 2 X New York Director 096-14-2163 Jsual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State Director MD Rockville Montgomery 1X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 20852 United States **Examiner must** 6121 Montrose Rd. 'natural", or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Verification Healthcare should be filed with and Mental Hygien 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Hatkoff Hannah Cohen permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1903 Sunrise Drive, Rockville, Maryland 20854 Nancy Sheintal -20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-29-2012 | Falls Church, Virginia 4 Donation 5 Other (Specify) King David Mem Gdns. 21. Signature of Funeral Service Licensee Brad Smetzer 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Chronic Pnysician/ obstruction airway disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** ementin Sequentially list conditions, Due to (or as a nonseque if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 Month 5 Other (specify) Pregnant at time of death 1 Yes 2 No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law a
24 hours after death.
 Funeral Director: After this certificate has b autopsy performed 1 Yes 2 No Yes 2 XNo Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending 2 🗌 No 1 🗌 Yes Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one 29c. License number 29b. Signature and title of certifie D00648 mina Farli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 Rockville Montrose 6121

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signati

JUN 0 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** 2012 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MI SALTIMOR rehabilitation & Health SEX If Under 24 Hrs. Hours Min. Social Security Numbe 8. Date of Birth (Month, Day, Year) April 2, 1924 Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 □ M 2 💆 Months Davs 216 18 4012 88 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10a. State 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shovevent, the Modical Exemiter must be collined at Maryland Baltimore Nottingham 1 ☐ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 Cardwell Ave. Apt.118 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 No If Yes, Give Year or Dates: Specify þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) of Health and Mental Hygiene. Item 27 is marked other than College (1-4or 5+) Clerk Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be George Robert Fisher Anna Catherine Betz ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Warren (Daughter) 6920 University Dr. Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 6/2/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATheroscleroke /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending p IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) P.O. detached 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform certificate 2 No 1 ☐ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **1** No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division of After this funeral 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of or Attending 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 Tes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated.

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

cause of death (Item 23a) (Type, Print)

's Signature

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32.

Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:00 A M Kunkel May\_ Gerard Francis Sr. Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Bel Air 128 W. Ring Factory Road 8. Date of Birth (Month, Day, Jan • 24 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Mary Land Director 87 212-20-3738 Usual Residence of Decedent 10d, Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a, State 10b. County Director 1 ☐ Yes 2 🗓 No Maryland Bel Air Harford 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral **USA** 21014 128 West Ring Factory Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 ★Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Automotive Parts Owner/Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Dorothea (nmn) Bilz John Neponucene Kunkel II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1617 Kingsview Dr., Bel Air, Maryland 21015 Mary Rosling / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burlal 2 ☐ Cremation 3 ☐ Remova 5 ktate permit. Page Department of Important: If any injury or once. Perryman, Maryland 6-2-2012 4 □ Donation 5 □ Offner (Specify) Spesutia Cemetery 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign tre of Funer Þ 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Obstruction Immediate Cause (Final Colonic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day Pregnant at time of death Unknown Yes 2 No 9 Unknown has been signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Discase 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? DESCESE 24a Was an pare performed 1 ☐ Yes 2 ☐ No 2 2 26. Place of Death (Check only one) 25. Was case referred to medical the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 Yes 2 No ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Projection: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number D35012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Hir , Md. 21014 J. Keria Lynet 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland / Dep Ce	artment of F rtificate of L		nd Mental Hy	/giene Reg. No. 2	012	17316
	Physicia		1. Decedent's Name (First, Middle Bonita	, Last)	Kofskey			2. Date of D Month May	eath		3. Time of Death 6:25 a M
- 84	Medie Examir		4a. Facility Name (if not institution, Gilchrist Hosp			4b. City, Town, or			4c. Coun	ty of Death	
, in	Funeral Director		5. Social Security Number 214–58–8118  Usual Residence of Decedent		e (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24		rth ay, Year)	9. Birth	place (State or Foreign
	laryland 3a-f show ified at	Director	10a. State 10b. County	timore	10c. City, Town or Lo	ocation Dund	alk		-	-	0d. Inside City Limits  1  Yes 2 No
	with the M 23a or 28 ist be not	eral Dir	10e. Street and Number 214 Parkwood F	load		10f. Zip Code	21222		10g. Citizen of	What Cour	
9036	within 72 hours after death with the Maryland jiene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ted by Funeral	11. Marital Status 1 ☐ Never Married 2 🛣 Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2【 No	ispanic Origin? ın, Mexican, Pı	? (Specify Yes or No uerto Rican, etc.)		ace - Americ	etc.
Baltimore, Maryland 21215-0036	within 72 hou rgiene. ner than "nati ner the Medica	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 6 years	t's Education st grade completed) College (1-4 or 5	(Give	dent's Usual Occup kind of work done o OO NOT use retired) HOUSEWI	during most of	working	16b. Kind of I	Business/In	
/land	should be filed wit n and Mental Hygie 7 is marked other raumatic event, the	To Be	17. Father's Name (First, Middle, L. Lawrance Beach					Name (First, Middle la Larrin		ne)	-
, Man			19a. Informant's Name/Relationsh Wayne Kofskey	ip (Type, Print) Husband	19b. Maili 214	ng Address (Street a	Road,	Rural Route Numb	er, City or Town, Md. 212	State, Zip (	Code)
imore			20a. Method of Disposition 1 ☐ Burial 2 🄀 Cremation 4 ☐ Donation 5 ☐ Other (S)			osition (Name of matory or other place Crematory	e) Ju Y 2	ne 4, 2012	20c. Location Baltim	,	wn, State Maryland
Balt	permit. Par Departmer Important any injury once.	( )	21. Signature of Fynera Service Li		elly 3	2, Name and Address Connelly 1 7110 Solle	Funeral ers Poi	. Home of .nt Road,	Dundalk Dundalk	, P.A Md.	°21222
i.,	Physician/ Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	the death. No not ent :. . M CU	er the mode of dying	g, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	b. ————	a consequence of):						
	ecuted and Il-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):						
200	icate be executed physician and is the burial-transit	edical		d						4	
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.  Within 24 hours affect death.  Within 24 hours affect death.  Completely filled in by the funeral director, page 2 should be detached for use as the burial-transic completely filled in by the funeral director, page 2 should be detached for use as the burial-transic completely filled in by the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal death 3 🛚	Ectopic pregnanc Other (specify)	у			ate of delive	ery Day Year
Division of Vital Records, P.O.	equires that the sen signed by nould be deta	ρ	Part II. Other significant condition	ns contributing to death bu	ut not resulting in the u	underlying cause giv	en in Part I.	23e. Did 1			e cause of death?
Reco	: The law r cate has b r, page 2 sh	Completed						24a. Was auto perfo 1 🗌 Yes	psy ormed?	Were autop prior to con death? 1 \( \subseteq \text{Yes} \)	osy findings available inpletion of cause of 2 No
Vital	ysician is certifi director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆 ER/Outpatier	Otho		Check only one) g Home 5  Resi	danca 6 N Ott	or (Procify)	homelie
on of	nding Ph ath. r: After th	Certificate:	27. Manner of Death Natural 5 Pending Accident Investige	28a. Date of injur (Month, Day,	y 28b. Time of	28c. Injury work	at		now injury occur		1000114
Divisi	cal or Atters after de al Directo ed in by the		3 Suicide 6 Could n 4 Homicide determin		ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location ( City or Tov	Street and Numb vn, State)	er or Rural	Route Number,
	he Hospit in 24 hour he Funera	Medical	(Check / 2 L. Medical Ex	Physician: To the best of r caminer: On the basis of ex Nurse Practitioner: To the	amination and/or invest	tigation, in my opinio	n, death occum	ed at the time date:	and place, and du	ie to the call	se(s) and manner stated
	To virt		29b. Signature and title of certifier	Cons		29c. License	number 830	03	29d. Date signe	d (Month, E	olay, Year)
	HJ		30. Name and address of person w	ho completed cause of de	eath (Item 23a) (Type, F	rint) Town B	lud.	Towson	n Md	. 21	204
	Stat Registra	-	31. Date filed (Month, Day, Year)  JUN 0 1 2012	32. Registrar	's Signature		•		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Laird 4:50 PM orman 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Secours Hospital Baltimore, If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1**X** M 2 □ F (Month, Day, Yes Days Hours Min. Year 218-62-9229 **Director** Feb. Usual Residence of Decedent 28a-f shov 10b. County ms 23a or 28a-f sho must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Tyres 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2206 Wilkens Avenue 21223 USA permit. Page 1 and 2 should be filed within 72 hours after death be pertiment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Medical Examiner Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. White If Yes, Give Year or Dates. Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Charlestown Elementary/Seconday (0-12) College (1-4 or 5+) the Retire. Community 12 Maintenance other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lorman L. Laird II Susan Lizel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Lorman L. Laird IV - Son 423 Lancaster Ave. Lancaster, PA 17603 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Crownsville Cem. XXBurial 2 Cremation 3 Removal from State Department of Important: If any injury or 05/31/12 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, I 4107 Wilkens Ave. Baltimore, MD 21229 Signature of Funeral Service Licensee Rosh 4107 Wilkens Ave. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Myocardial Infarction Physician disease or condition resulting in death) Medical Examine Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 Yes 2 No Yes Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Beath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined after within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Frequency Time basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Doole 3545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bon Secous Harpi's 2000 W. Baltimore St Baltz, Thompson,

DHMH 17 Rev 7/2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Tiedse i	State of Marylan						_	o.	7010
			1 - State Registrar				of Death		Reg. N	7111	2 1	1318
	° Physici	an	Decedent's Name (First, Middle, Last					2. Date Mor			ear 10	me of Death
	/Medic	al	Irving Isid  4a. Facility Name (If not institution, give		ipskin		m, or Location of	May Death		20.		:53 Рм
	Examin	er	Bedford Court Nu				lver Spr				gomery	
夏	. Funeral		5. Social Security Number 6. Se	X 7. Age (In yrs.		If Under 1 Y	ear If Under 24	4 Hrs. 8. Date	e of Birth oth, Day, Year	) 9.	Birthplace (S Country)	tate or Foreign
	Director		111-18-3557 Usual Residence of Decedent	X <sup>M</sup> <sup>2</sup>   86	Yrs.			Nov.	3, 19	25	New Yo	rk
	yland how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						ide City Limits
	89-1 s	Director	MD Montgo	mery			er Sprin	ıg				Yes ZX No
	death with the Maryland ms 23g or 28e-f show		10e. Street and Number 3200 N. Leisure W	14 B14 #24	26	10f. Zip Co				itizen of Wha		
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.			20906 of Hispanic Origin Cuban, Mexican, I	n? (Specify Ye		14. Race ·	States American Indi	
20	hours after tural', or Ite		1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Kores	.   '	iires, specily i 1 ☐ Yes 2 💢		Pueno Hican, e	HC.)	Specify:	White, etc. Whit	Δ.
و 200	be filed within 72 hours after death with the Marylan del Hygliene. other then "netural", or liems 23a or 28e-1 show event. The Macilcal Examiner ment be notified at	ed by	3 Widowed 4 Divorced  15. Decedent's Edu			dent's Usual O			16h	Kind of Busin		
2	within 72 ene. then "nei hs wedic	Completed	(Specify only highest grad Elementary/Secondary (0-12)	fe completed)  College (1-4or 5+)	(Give	kind of work d DO NOT use re	one during most o	of working	.05.	4,7,0 0. 0.00	,	
7	e filed wit Il Hygiene other the vent, the	Соп		5+	Eleme	entary	School P			Educat	ion	
yland		) Be	17. Father's Name (First, Middle, Last) Samue1	Lipskir	nd			s Name (First, Via		n Sumame) Morgar	stern	
	s 1 and 2 should be f Health and Mental item 27 le marked other treumetic ev	오	19a. Informant's Name/Relationship (T)		-	ng Address (St	reet and Number					20906
e, ma	D = F =		Diane S. Lipskind		_	A STATE OF THE STA	re World					, MD
Jore	8°2 = 5		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State	emetery, crer	osition (Name of matory or other	place)	Date			y or Town, Sta	
altimor	permit. Pa Departmen Importent: eny injury once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens				atory   0				lle, M	D
Ď	permit. Departm Importer eny inju		Allice Is	ur MØ1541			ddress of Facility eral and Ave., S				3 20 <b>9</b> 10	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o		h. Do not ent	er the mode of	dying, such as ca				Appro Interva	ximate al Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	•	YOPP	THY				Onset	and Death
	Examiner			Due to (or as a conseq	uence of):							
=	, , , , , , , , , , , , , , , , , , ,	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):						50	
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq.	uance of):							
Š.	ate be executed nysician and he burial-transit	cal E		d.	001100 017.							
0	certificate nding phy use as the		IF FEMALE:									
X O O	ath ce	lan/h	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2□Feta	Ideath 3□	Ectopic pregn			4	23d. Date o		Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5L	Other (specif	V)					
L O	The law requires that the death certifica ate has been signed by the attending ph. page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying caus	given in Part I.	230	e. Did tobacco	use contribu	te to the caus	e of death?
ecords,	require een sig rould b		KIF	(A) F1134	700	11010		-	1 Yes	2□No 3[	Probably	4 Unknown
ည ရ	ne faw has b ge 2 st	Completed						248	a. Was an autopsy performed?	24b. Wei prio dea	r to completion	lings available n of cause of
NII A		0	25. Was case referred to medical				26 Place o	1 □	Yes 2 N	0 1 🗆	Yes 2□No	
5	hysici	To B	examiner?	Hospital: 1 🗌 Inpatient 2 🗍	ER/Outpatier	nt 3□ DOA	Othor	sing Home 5		6 Other	Specify)	
	ling Pl	iuoj:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		scribe how inj	ury occurred		
NISION	Attend r death octor: by the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, str		1 ☐ Yes 2 ☐ No ice	28f. Loc	ation (Street a	nd Number	or Rural Route	Number,
5	tel or rs afte el Dire ed in b	Certification;	4 Homicide	building, etc. (Specify	V)			City	or Town, Sta	ře)		
	or the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certifica completely filled in by the funeral director,	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exemi	sicien: To the best of my kno ner: On the basis of examina	wledge, death tion and/or in	n occurred at the	ne time, date and my opinion, death	place, and due occurred at the	to the cause( e time, date ar	s) and manne nd place, and	er as stated. I due to the ca	use(s)
	Fo the within 2 roundle	Mec	29b. Signature and title of certifier	and manner stated.	<b>N</b>	29c. Lie	cense number		29d. D	ate signed (A	Month, Day, Ye	ear)
	1		mhe	M.	D-	(	1573	13		5/20	1112	-
	107		30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type,	Print)	- drive	e Elli	cott	cilia	M 2	1047
	Sta	te	31. Date filed (Month Day, Year)	32 Registrar's Signa	in the same of the	710101	CV	0 011	.0011	-10	, , ,	1-10.
	Registr		.IIIN 0 1 2012 A	men i sein.	William .					,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 2,29d per doc g928 6-14-12 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29 Physician/ Month Mary Elizabeth Haupt Mitchem ລັ 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL Rosedale Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Hours Months Min **Director** 220-12-7582 1 M 2 KX 85 Yrs Maryland May 24, 1927 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director notified Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Numbe 23a or 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral USA 1641 Northwick Court 21218 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian by Black, White, etc. 1 Never Married 2 Married 21215-0036 White 1 Yes 2X XNo Specify: Specify 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) C&P Telephone Accounting Supervisor marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Emma Virginia O'Neil William Charles Haupt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S of Health 36 Robin Lynne Court Perry Hall MD Mary Holcomb/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important, If ite any injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Woodlawn Cemetery 6/2/12Woodlawn MD 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Lice <sup>22</sup> Name and Address of Facility Leonard J. Ruck Inc. 5305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Preumonia Medical **Examiner** Renel Faihur Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law this certificate has completely filled in by the funeral director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certific 29c. License number 29d. D29signed (Month, Day, Year) DO067697 auchy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 SAUCHEZ -CRESPO NELIA E. 9000 FRANKLin Square Balto md 21237 DR 32. Registrar Signat State O NUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 214/ M 201 Arley Antonio Mairena Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George 3120 Brinkley Road Apt #103 Temple Hills Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) 11/28/1950 578-74-3702 1 X M 2 □ F 61 Nicaragua **Director** Usual Residence of Deced or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Prince George Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Nicaragua 20748 3120 Brinkley Road Apt #103 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Forces? þ 1 Never Married 2 K Married 1 → Yes 2 → No Specify: Nicaraguan If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Heating/Air Condition Engineer Self-Employed 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maria J. Juarez Guillermo Mairena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3120 Brinkley Road Apt #103 Temple Hills, MD 20748 Ree Mairena - Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 6/1/2012 Falls Church, VA Danzansky-Goldberg Signature of Funeral Service Brad Smetzer 22. Name and Address of Facility 1170 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the sehould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has autopsy this certificate 2 No 2 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examino?
Yes 2 No Other: ပ 4 Nursing Home 5 Residence 6 Dther (Specify) 1 Inpatient 2 ER/Dutpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After 5 Pending 1 Natural work? 24 hours after death. Funeral Director: Al 2 No Investigation Accident completely filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

58W

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar

ate 131. Date filed (Month, Day, Year) / 32. Registrar's Signature rar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760,	
al or Attending Physician: The law requires thet the death certificate be executed after death	Phy /M Exa
I Director: After this certificate hes been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit	sicia: ledica amine

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		State of Maryland / Department of Health and Mental Hygiene 20   2   732  Certificate of Death  Reg. No.												
Physicia	an	Decedent's Name (First, Middle, Last)							2. Date of De			ath 3. Time of E		
/Medic	al	George Irvin Murray  4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death			·		. County of Death	2:32 A M	
Examin	er	7209 Johnnycake Rd.					Catonsville				Baltimore			
Funeral Director		5. Social Security N 213–26–1	211	Sex 1XIM 2□F	7. Age (In yrs. 82	last birthday) Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birth (Month, Day, Year) 01/10/193		9. Birthplace (State or Foreign Country) MD		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If Item 27 is marked other than "nature"; or Itame 23s or 28s-1 ehow applying or other traumatic event, Ita Madical Examinationals be notified at an once.		Usual Residence o	10b. County		10c. C	ity, Town or Lo	ocation					1	10d. Inside City Limits	
	tor	MD Baltimore Cato					nsville				1 ☐ Yes 2 🛣 No			
	Direc	10e. Street and Number				10f. Zip Code					10g. Cit	tizen of What Cour	ntry?	
	eral	7209 Johnnycake Rd.  11. Marital Status  12. Was Decedent E			edent Ever in I	10 13		21228  /as Decedent of Hispanic Origin? (Specif				USA 14. Race - Americ	can Indian	
	by Funeral Director	Armed Forces  1 ☑ Never Married 2 ☐ Married  1 ☑ Never Married 2 ☐ Married  1 ☑ Yes 2 ☐  If Yes, Give Year or Dates:			orces? 2  No ve		f Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ☑ No <i>Specify:</i>			Rican, etc.)	Black, White, etc.  Specify: White			
	Completed	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during			on ring most of working			6b. Kind of Business/Industry		
	ршр	Elementary/Secondary (0-12) College (1-4or 5+)					DO NOT use retired)  Phouse Clerk			Sı		pice / McCormick		
	To Be Co								Name	Spice / McCormick ne (First, Middle, Maiden Surname)				
		George I. Murray, Sr. Evelyr								n Bennett				
		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural R								Route Number, City or Town, State, Zip Code) atonsville, MD 21228				
		20a. Method of Dis	<u>`</u>	Niece		Place of Dispo	sition (Name of	1		atonsv:		ocation - City or To		
		1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory (Atlantic Crematory)										en Burnie		
Depa Impo Impo eny ir		21. Signature of Funcial Service Licensee  Daniel Simons  22. Name and Address of Facility  Hubbard Funeral Home, Inc.  4701 Wilkens Ave., Baltimore, MD 21229												
Physician /Medical	I Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Artland Sclendfic Candrovascular Disease												
Examine be executed bhysician and bhysician and si the burial-transit		Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):												
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To the Hospital or Attending Physician: The law requires thet the death certifics within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physometery filed in by the funeral director, page 2 should be detached for use as it	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown									23d. Date of delivery  Month Day Year			
	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 Unknown					
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dcian: certific rector,	Be	25. Was case referred to medical examiner?  Hospital:								(Check only one)				
Phys r this ral dir	5	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Cher. 4 Nursii  27. Manner of Death 1 Natural 5 Pending (Month, Day Year)  28. Date of Injury 28b. Time of Injury at Work?								Home 5 Residence 6 ⊡Other (Specify)  28d. Describe how injury occurred				
ath. rr: Afte	atior	1 Matural 2 Accident	5 ☐ Pending investigat	(Mon	nth, Day Year)	Injury		k? Yes 2 □No	1					
To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3  Suicide 4  Homicide	6 ☐ Could not determine	ed 289. Place	28e. Place of Injury - At home, farm, stre building, etc. (Specify)			et, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	edical	29a. Certifier (Chack only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	Σ	29b. Signature and	Attette D	d an	lepu-	¥	29c. Licens	number	7_	1		te signed (Month,		
		30. Name and add	a Mil.	telle,	se of d _th (Ite M) Registrar's Sign	Trime	/ / / / /	CTL	4	honu	:11	= Md =	1092	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 9:30 А. м William Frederick Marney May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 622 Bruce Street Anne Arundel Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Davs Hours 215 28 8055 Director 80 1 😿 M 2 🗆 F 08/06/1931 Maryland 28a-f show should be filed within 72 hours after death with the Maryland at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No Maryland Baltimore Anne Arundel o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **23**a Funeral U.S.A. 622 Bruce Street 21225 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? ò Completed by Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 White 1 Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates. Korean injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel Steel Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Wiliam Bernard Marney Minnie Duvall and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is Margaret Sweeney / Daughter 2812 Summit Avenue Baltimore, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 05/30/2012 Baltimore, Maryland Bavview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fureral Service Lic, Gonce Funeral Service, P.A. 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si i n disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 1 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Hospital: 힏 2 🕱 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a

Registrar

DHMH 17 Rev 06-2011

State

West

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month 9:40AM M Nicholas Paul Marinaccio May 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House <u>Rockville</u> Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours **Director** 1 ▼ M 2 □ F <u> 105–44–7377</u> October 28, 1954 Usual Residence of Deceden New York other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Montgomery <u>Rockville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16680 Emory Lane 20853 <u>United States</u> filed within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Restoration Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Menta မှ Page 1 and 2 should be Nicholas James Marinaccio Evelyn Marie Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9039 Sligo Creek Parkway #1416 Silver Spring, Maryland 20901 <u>s</u> Heelth tem 27 George T. Kephart/ Partner 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 0 = 0 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) permit. Page Department of Important: If any Injury or once. Gate of Heaven Mausoleum June 2012 4 □ Donation 5 🗓 Other (Specify Entombment Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 Signature of Funeral Service License M00335 23a. Part 1. Enter the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year signed by the a 9 🔲 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown certificate has been s irector, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛣 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death **Certificate:** 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending ours after death. leral Director: Aft filled in by the fu 1 🗌 Yes ☐ Accident ☐ Suicide Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier R143201 IDV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller. CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20855 32. Registrar's genature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:56 PM MAY Gerald David Miller Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Hospital of Baltimore Baltimore N/A Funeral Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 218-74-7709 1 **⊠**M 2 □ F 53 May 15, 1959 Maryland Usual Residence of Dec show 10a. State 10b. County 10c. City, Town or Location rector 10d. Inside City Limits must be notified 28a-f 1 X Yes 2 No Maryland Baltimore ö ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 212 Wa<u>shburn Avenue</u> 21225 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces ō Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after ☐ Yes 2 🗷 No 5-0036 1 ☐ Yes 2 🗷 No Specify: "natural", 3 Widowed 4 Divorced If Yes, Give Completed Specify: Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 N/A Truck Driver George J. Falter Co. other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 2 should be Miller Leroy Sadie Tontz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Sarah Kline fiancee 212Washburn Avenue Baltimore, MD 21225 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🛣 Cremation 3 🗀 Removal from State injury or cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 06/01/2012 Glen Burnie, Maryland any in 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
237 East Patapsco Avenue Baltimore, Maryland 21225 MOD-732 2 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Imonary disease or condition DAI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examiner Due to for as a numer tience of cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 2 No signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by plnous 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? After this certificate ha funeral director, page 2 🗌 No res 2 No Be 25. Was case referred to medical 26. Place of Death (Check only e) Hospital 2 **A**o Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide
Homicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one vilitile of certifier 29b. Signature 29c. License number ES-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARY VIRGINIA MARCUM May 30, 2012 **Physician** 5:23 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Parkville Baltimore 2812 Garnet Road 8. Date of Birth (Month, Day, 1) June 18, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 213-28-7471 Months Days Hours <sup>Year)</sup> 1932 1 □ M 2 🕱 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Modeal Exprinted mast he notified and anote. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Baltimore Maryland 1 ☐ Yes 2 😿 No Directo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21234 2812 Garnet Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 
Yes 2 
No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify. ò Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife & Mother 0 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Hite Fmma ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James Marcum (Son) 2812 Garnet Road, Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 6/4/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McOully-Polyniak Funeral Home, F.A. 2 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 MO0175 Approximate Interval Between Onset and Death 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pontine Cerebrovascular Accident **Physician** 2 weeks /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hyperlipidemia Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Atherosclerotic Cardiovascular Dispase Physician/Medical the attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ■ No Month Year 4 ☐ Pregnant at time of death certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Atrial fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 2 🗆 🖍 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUN 0 1 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 LochRaven Blod Baltimore MD 21239

140277

May 30,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per INF G928 6/04/2012 JH/ #13,14perFH. G929.7/6/2012, WS State of Maryland / Department of Health and Mental Hygiene

Amen Item 25 per me, g928,06/29/2012 at the Death Reg. No. 20 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician /Medical 20/2 NUNEZ 1ar10 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 12/19/41 5. Social Security Number 070-40-503 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**XX**M 2 □ F 4991 70 Dominican Rep. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c City Town or Location 10b. County Baltimore MD N/A 1 StYes 2 No Director 10e. Street and Number 4832 Wright Street 10g. Citizen of What Country? 10f. Zip-Code 21205 USA Funeral 14. Race - American Indian, Black, White, Black Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 

Yes 

Yes 

Specify: White Specify: ð Domincan 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Store Manager Phone 0 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ceverino Alfonso Martinez Maria မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 96-09 23rd 11369 East Elmer NY Nelson Nunez /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3X Removal from State 5/21/12 Cypress Hills Cemetery Brooklyn 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 21. S pature of Fune I Service Licensee Victor Doda 1501 E. Fort Avenue, Baltimore MD 21230 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that causes shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** erehrai disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner FXAMINER The law requires that the death certificate be executed as the burial-transit Subqyachno Due to (or as a consequence of): ROVED BY MED attending physician and **CERTIFICATION A** Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Tyes 2 **N**O 1 ☐ Yes certificate or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completely filled in by the funeral director, Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 XYes <del>2 N</del>o Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) hours within 24 hours a 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RESOOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Dria.M. 31. Date filed (Month, Day, Year) **JUN 0 1 2012** State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar		artment of F rtificate of E		•	Reg. No. 2	012	17327	
	Physicia	n/	Decedent's Name (First, Middle, Las.     Morris		erman			2. Date of De Month	ath Day 29,	2012	3. Time of Death 12:00 P M	
	Medic Examin		4a. Facility Name (if not institution, give		.erman	4b. City, Town, or	Location of Death	May		Inty of Death	112:00 P	
			Brighton Gardens	Assisted Livi	.ng		y Chase	N.		Montgo	mery	
	Funeral Director	1	5. Social Security Number  103-01-3037  Usual Residence of Decedent	x	ast birthday) Yrs.	If Under 1 Year Months Days						
	and show d at	to	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits	
	Mary 28a-f otifie	irec	MD Montgo	omery			Chase				1XXX Yes 2 □ No	
	ith the	Funeral Director	10e. Street and Number	21 1 ///06		10f. Zip Code	2015			of What Coun		
	ems 2	une	5555 Friendship 1	12. Was Decedent Ever in U.	S. 13.		)815 spanic Origin? (Sp	ecify Yes or No-		ted St		
036	ould be filed within 72 hours after death with the Maryland and Mentylane.  Marked other than "natural", or items 23a or 28a-f show marked other than "natural" are items to notified at matic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 1942-46		3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer   1 Yes 2XXNo Specify:		Rican, etc.)	Spec	Black, White, $\epsilon$	hite	
Maryland 21215-0036	72 hou n "natu Aedica	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occupa kind of work done d OO NOT use retired)	nt's Usual Occupation nd of work done during most of working NOT use retired		16b. Kind o	of Business Inc	lustry	
212	within giene. er tha t, the N		Elementary/Seconday (0-12)	College (1-4 or 5+) 5+		incipal		· -	Edu	cation		
and	ntal Hy ced oth	To Be	17. Father's Name (First, Middle, Last)  Mendel	Nie	rman		18. Mother's Nam	ne (First, Middle,	Maiden Surna	<sub>ame)</sub> Javitz		
aryi	should be file and Mental I is marked of raumatic eve		19a. Informant's Name/Relationship (Ty		T	ing Address (Street a		al Route Numbe	er, City or Tow		ode)	
	of and 2 should be of Health and Menta fitem 27 is marked rother traumatic e		Elena Widder / Da			Riley Ro	l., Silve	er Sprin		2091		
Baltimore,	Page 1 а ment of H :ant: If ite ury or otl		20a. Method of Disposition  1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery cre	osition (Name of matory or other plac ke Cremato	ery 05/3	Date 30/2012		on-City or To .tsvill		
Balt	permit. Page Department. Important: I any injury or once.		21. Signature of Funeral Service Licens	moe38	2   <sup>2</sup> 1	2. Name and Addres Kapp Fune 1933 Gist	s of Facility Cal and ( Ave., Sil	Crematic Lver Spr	n Serv	rices D 20	910	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the deat ne cause on each line.							Approximate Interval Between Onset and Death	
*	Ph <sub>sician/</sub> Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to for as a consequence	art fa	elur	2>			- /		
	Examiner	L	Sequentially list conditions,	COPD(a	Bronie	c obstr	ictive p	rehmor	any o	lisense	3/2012	
	ed sit	if any, leading to immediate cause. Enter Underlying  Cause (Disease or iinjury  Due to (or as a consequence of):  Cause (Disease or iinjury										
	ath certificate be executed attending physician and for use as the burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or as a consequence)	ue ice of):	reag	20/3/201	10				
200	ate be whysicia	edical		d					·			
89	certifica inding p use as t		IF FEMALE: 23b. Was decedent pregnant	23c. If <u>ye</u> s, outcome of <u>pr</u> egna	incy				23d	Date of delive	erv	
. Box	that the death oned by the attered by the atteres detached for u	Physician/N	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live Birth 2 Fets 4 Pregnant at time of g Unknown		☐ Ectopic pregnanc☐ Other (specify)	у				Day Year	
	ires that the dea signed by the a d be detached f	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the	underlying cause giv	en in Part I.				e cause of death?	
Records,	The law requires ate has been sign page 2 should be	Completed						24a. Was			osy findings available mpletion of cause of	
	: The law cate has ; page 2							perfo	ormed No	death?	2 No	
/ita	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ED/Outpatio	- Othe	er:	ck only one) ome 5 $\square$ Resi	danaa Ma	Other (Specific	Assisted Living	
) ot	Attending Physician: or death. ector: After this certific by the funeral director,		27. Manner of eath  1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time o injury	28c. Injury work	at ?	28d. Describe			V	
Division of Vital	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined				Yes 2 No	28f. Location (		mber or Rural	Route Number,	
۵	ospital of hours at ineral D	Medical C		ician: To the best of my know								
	the Hittin 24 the Fu	Mec	(Check 2 Medical Examination only one) 3 Certifying Nurs 29b. Signature and title of certifier	ner: On the basis of examination e Practioner: To the best of m	n and/or inves y knowledge,	death occurred at the	time, date and pla	at the time, date a ce, and due to the	ne cause(s) and	d manner as sta	ated.	
	<b>1</b>		235. Signature and title of certifier	Vo.	RNIF	29c, License	750A		29d. Date sig	gned (Month, 1 29/	20/2	
1	19t',		1	ompleted cause of death (Iten		Print)	Wiscon	_ \ 4	#	Bet	hesday,	
	Stat		Wendy Wang 31. Date filed (Mohth, Day, Year)	at Silva (		11/59	Wiscon	nsin A	Ne 721	/	NO 20814	
	Registra		JUN-0 1 2012 .	and the	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 25,2012 MICHAEL J. NAGLIERI, SR. 9:45P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTO. NOTTINGHAM 3-D BEESON COURT If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth Hours Months Days (Month, Day, Year) 217-16-5052 Director 1 XM 2 - F 87 Yrs JUNE 8,1924 MARYLAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "nstural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No NOTTINGHAM BALTO. MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai USA 21236 3-D BEESON COURT Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 🙀 Married 1 ☐ Yes AXX No WHITE 1 ☐ Yes 2 👿 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BONDING LAYUP GLENN L. MARTIN 8 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ANGELINA SPADACCINI **LOUIS NAGLIERI** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO. MD. 21237 5268 GLENTHORNE COURT DTR. SHERRY R. HOLT Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MIDDLE RIVER, MD. 5-30-2012 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILL of Fun all Service Licenses SCHIMUNEK FUNERAL HOME, INC. 22. Name and Address of Facility NOTTINGHAM, MD. 21236 9705 BELAIR ROAD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learl failure. List only one cause on each line. Immediate Cause (Final Onset and Death Enysician, STAGE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the buriai-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the at id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ of Vital Records, 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ours after death.

Brail Director: After this certificate?

filled in by the funeral director, page 2 No 1 Tes 1 Yes Hospital or Attending Physician: B 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 X Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medicai To the Hospi within 24 hou To the Funar completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 2012 of person who completed cause of death (Item 23a) (Type, Print) NN 7300 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date Month 2. Date of Death 3. Time of Death Physician/ Mildred Louise Powers 201 5]30 AMM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5201 Pembroke Avenue Baltimore N/A . Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Min 217-12-9097 Director 1 M 2 X F 87 Oct. 10, 1924 Maryland show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director N/A Baltimore 1 X Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21206 5201 Pembroke Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 🙀 No Specify: Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b, Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Marjorie Rowe 17. Father's Name (First, Middle, Last) ပ John Mules 19a. Informant's Name/Relationship *(Type, Print)* Daniel M. Powers/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4117 White Avenue Baltimore MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Baltimore MD 5/30/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore MD Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 12 months? 2 No Month Day Pregnant at time of death Other (specify) 9 Unknown a Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate has To the Hospital or Attending Physician; 1 within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at injury work?
1 Yes 2 No 5 Pending Natural Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signedi/Month. Day. Year

Registrar

DHMH 17 Rev 06-2011

State

30. Name and a

Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 Lester Poretsky 2012 4:47 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) Director 577-14-7596 1 X M 2 D F 91 12-14-1920 PA shov a filed within 72 hours after death with the Maryland that Hygiene.

ad other than "natural", or items 23e or 28a-f sho event, the Medical Eventiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Chevy Chase 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8101 Connecticut Avenue 20815 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Architect Own Business Be permit. Page 1 and 2 should be filed Depertment of Health and Mental Hy Important: If item 27 is marked oth any lijury or other treumetic event ang. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Harry Poretsky Dora Baitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erma Poretsky - Wife 8101 Connecticut Avenue, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Judean Memorial Gdns 5-27-2012 Olney, Maryland 21. Signature of Funeral Service Licensee Brad Smetzer 22. Name and Address of Facility Danzansky-Goldberg Vind 1170 Rockville Pike, Rocville, Maryland 20852 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Return Interval Between Onset and Death Immediate Cause (Final Physician/ Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Attending Physicien: The law requires that the death certificate be executed ettending physician and for use as the burlal-translt Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, npleted 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? Com performed? Yes 2 M No After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide 5 Pending injury Division 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201 5.26.17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller - 6001 Muncaster Road, Rockville, Maryland 20855 State Registrar

DHMH 17 Rev 06-2011

Box 68760

P.0.

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 2:38 A M Walter N. Phillips May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Yea Aug. 17, . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Year) Hours **Director** 89 218-18-4252 1 XM 2 □ F 1922 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director Columbia 1 Yes 2X No MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 5400 Vantage Point Rd. 21044 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 1 No. 1942 Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1942–45 Year or Dates. 1949–51 1 ☐ Yes 2 🗓 No Specify. White "natural" Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)
Marketing/ Technical (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Aerospace marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H Walter Phillips Sr. Elsie Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 7391 Minter Lane, Clarksville, MD Kent A. Phillips / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 05/25/2012 Bethesda, MD 4 X Donation 5 Other (Specify) Uniformed Sers. Univ. 21. Signature of Funeral Service Licensee M00382 Rappe FineralFaind Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) RESPIRATORY FAILURE Medical Due to (or as a consequence of): Examiner MALIGNANT PLEURAL EFFISSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami The law requires that the death certificate be executed attending physician and for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the at d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2X No Director: After this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) was case examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1XXNatural 5 Pending injury work' 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29c. License number D. 0032247 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05

Opx 1

Registrar
DHMH 17 Rev 06-2011

State

1500 FOREST GLEN RD., SILVER SPRING, MD

20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

NOOSHIN FARR M.D.,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara Month Year 3:30PM Mny Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Center Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 217-38-8303 **Director** 1 □ M 2 🗓 F 78 June 28, 2933 Ohio 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d, Inside City Limits Director 1 🗆 yes 💥 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8218 Thornton Rd. 21204 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Completed by 1 Never Married 2 Married Black White etc. 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Medical Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Merrick Amelia Ε. Massick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Dorsey / Social Worker 611 Central Ave., Towson, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4X Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 05/25/12 Bethesda, MD 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ END STRUE DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate clause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ed by the atter in the past 12 month 1 Yes 2 No Pregnant at time of death Month Day Year g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? Yes 2 No death? 1 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 6 Other (Specify) 2 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15kijapchuMD 00057465 Baltimore MD 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 (min 1V NJ REGULARIO 5 663

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0

32/ Registrar's Signatu

Jason Antwan P		n 1- For State	Stat	e of Maryla			tment of		d Menta	al Hy		2	0.1	2 1733
Physicia		Registrar  1. Decedent's Name (Fil	rst, Middle,L	ast)			noute of	Death		1:	R 2. Date of Dea	teg. No.	UI	3. Time of Death
Medical Exami		JASON ANTW									Month May 28, 2	Day Y	ear	2305 hrs
		4a. Facility Name (if not			mber)		4	b. City, Town, o	Location of	Death	, , , ,	4c. Count	y of Deat	h
		S/B Rt 5 south	of Woody	oodyard Road C			Clinton				Prince	Georg	e's	
Funeral		5. Social Security Numb	er 6.	Sex 7. Age (In yrs. last birthday)			If Under 1 Year If Under 24Hrs.		_					
Director		220-21-1517	1	X M 2 F	23		Yrs.	Months Day	s Hours	Min.	12/28	3/1988	Forei Co	ountry) MD
	t	Usual Residence of Dec	edent					1				•		
v any			County			-	own or Locati	on						10d. Inside City Limits
and show	ō	MD P	PG		C	LIN'	TON							1 X Yes 2 No
Maryl 28a-1 d at c	Director	10e. Street and Number						10f. Zip Code			1	10g. Citizen of V	Vhat Cou	intry?
3a or		5306 RIGA	STREE	Γ				207	735			US		
h with	Funeral	11. Marital Status	- <b>-</b>		12. Was Decedent Ever in U.S. Armed Forces?			Decedent of Hi					ce - Amei ite, etc.	rican Indian, Black,
or ite	뒨	1 Never Married	_	1 Yes	2 😾	No	· ×				BLA			CK
s afte	à			or Dates:				1 Yes 2 No specify: Specify: Specify: ecedent's Usual Occupation (Give kind of work done					n - d d	
hour Fran	eted	<ol> <li>Decedent's Educat</li> <li>Elementary/Secondar</li> </ol>		College (1		a) 1		s Osual Occupa st of working life				16b. Kind of t	susiness/	industry
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5-0036 led within 7 Hygiene. I other than	Comple	17. Father's Name (First	, Middle, La	st)			WAKEH	OUSEMAN	18.Mother's	Name (	First, Middle,		PRIVATE iden Surname)	
215 be files ntal Hy rked o	BeC	STERLING PATTEN  BETTY JENKINS												
21.	2	19a. Informant's Name/F		(Type, Print)			19b. Mailing	Address (Stree				mber, City or To	wn, State	e, Zip Code)
MD d 2 sho lith and n 27 is		BETTY JENK	INS/M	OTHER			5306	RIGA STE	REET,	CLIN	TON, MD	20735		
	Ī	20a. Method of Dispositi						tion (Name of ce			Date	20c. Location	n - City or	Town, State
nor ages ant of at: 11		1 A Burial 2 C						ION CEME	TEDV	6-1	-2012	CLINT	ON,	MD
Baltimore, permit. Pages lar pepartment of Hee important: If ite	ŀ	21. Signature of Funeral			90108			ame and Addres				RAL HON	(E.S.	РΔ
Balt permit. Depart Import		Lex -	la in	0-			5.5	38 MARI	BORO 1					
Physician		28a. Part I. Enter the dis			used the d	eath. D	o not enter th	e mode of dying,	such as car	diac or i	espiratory arr	est, shock, or h	eart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final		<sub>a.</sub> Head Injurie	es									Death
LAdillilei		or condition resulting in	death)	Due to (or as a	consequen	ce of):								
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
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60, ate be ohysic		IF FEMALE:		23c. If yes, o	outcome of	pregnar	ncy		-		<del></del>	23d, Date	of deliver	y
6876( certificate nding physe as the b	sician/Me	23b. Was decedent pregress 12 months?	nant in the	1 Live bi				al death 3	Ectopic p	regnan	У	Month	ı	Day Year
Box 68760 e death certificate be the attending physical for use as the bu	sic	1 Yes 2 No 9	Unknov	· —	antattime o wn	or death	<sup>1</sup> 5 Oth	er (Specify)						
D. By the de	Phy	Part II. Other significan	t condition			not resu	ulting in the ur	derlying cause	given in Part	l.	23e. Did to	obacco use con	tribute to	the cause of death?
f, P.O. ires that the signed by 1 be detache	9										1 Yes	s 2 🗸 No :	3 Prol	bably 4 Unknown
Cords, law requir has been s	etec								_		24a. Was			utopsy findings available
col	Completed											rmed?	death?	completion of cause of
tal Rec cian: The certificate ector, page		25. Was case referred to	medical					26 Place	of Death (C	heck or	1 Yes	2 No	1 🗸 Y	es 2 No
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of Valing Phy	<b>⊢</b> †	1 Yes 2 27. Manner of Death	No	28a. Date	of Injury	28	8b. Time of In	jury 28c. Inju	ry at Work?		8d. Describe	how injury occu	rred	
ion tendin eath. tor: A	흲	1 Natural 5	Pending				OUND: 258 hrs	1	Yes 2 ✓ N	。 lb	river of an	auto that c	ollided	with fixed objectsf
or Att free de Directe in by	Certification:	2 Accident 3 Suicide 6	Investiga Could no	280 Place				, factory, office t	ouilding, etc.	2	8f. Location (	Street and Num	ber or Ru	ıral Route Number, City
Div	E E	4 Homicide	determin		Major R	Road /	Highway			S	or Town, S /B Rt 5 sout	tate) h of Woodyar	d Road,	Clinton, MD
E Hos		29a. Certifier 1 Cert	ifying Phys	cian: To the best	of my know	wledge,	death occurr	ed at the time, d	ate and place	, and d	ue to the caus	se(s) and manne	er as stat	ed.
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Fluoral Director: After this certificate has been signed by the attending phys completely filled in by the fluoral director, page 2 should be detached for use as the b	edical			er:On the basis o and manner st	f examinati ated.	on and/	or investigati	on, in my opinior	, death occu	rred at t	he time, date	and place, and	due to th	e cause(s)
	Σ	29b. Signature and title	of certifier					29c. Licens						nth, Day, Year)
		Yuna 198	uthal	(m)				O.C.	M.E.			May 29, 2	:012	
A	Ī	30. Name and address of		•	,		,	VA/ D-11:	- C4::	) - II.	110.0	4000		
- \		Pamela E. Sout	ınaıl, MD				and the same	W. Baltimor	e Street, I	aitim	ore, MD 2	1223		
St	ate	31. Date filed (Month De	N'II'I	2012 32. M	gistrar's Sig	nature	Lan	N.J						

2-03889 Sylvester Rodgers	Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hyg 1-For State  Certificate of Death		2 173
Physician	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year	3. Time of Death
Medical Examine	Sylvester Rodgers  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	May 22, 2012	0102 hrs
	University Hospital STU Baltimore	N/A	
Funeral Director		8. Date of Birth (MM/DD/YYYY) 9. Bir 3 / 4 / 5 4 Foreig Co	thplace (State or gn un(N)Y
how any	Usual Residence of Decedent  10a. State		10d. Inside City Limi
death with the Maryland or items 23a or 28a-f show any must be notified at once.		10g. Citizen of What Cour	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f sho injury or other traumatic event, the Medical Examiner must be neitlifed at once To Ba Completed by Funeral Director		ican, etc.) White, etc. Africa	ican Indian, Black, n er.
5-0036  cd within 72 hours a other than "natura the Medical Exami	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  Drt. Driver		•
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	unk	First, Middle, Maiden Surname) e Rodgers	
MD 21 nd 2 should alth and Me m 27 is ma numatic cv	Gwendolyn Tollver/Sister 2707 Monor Greim B	ane, Suwanee, GA	30024
Baltimore, oermit. Pages I am Department of Heal Important: If iten injury or other tra	1 Burial 2 Cremation 3 Removal from State Mt. Carmel Cem 6/2	Date 20c. Location - City or Balt., MD	
Ball permit Depar Impo	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Har 5126 Belair Rd, B		
Physician /Medical Examiner	23a. Part I. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):	espiratory arrest, shock, or heart	Approximate Interv Between Onset an Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ordinal Contification: To Re Commleted by Physician/Medical Expedical  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   2   Set opic pregnancy   1   Yes 2   No 9   Unknown   2   Unknown   2   Set opic pregnancy   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Live birth   3   Ectopic pregnancy   1   Live birth   3   Live birth   4   Live birth	cy 23d. Date of deliven	y Day Year	
P.O. Best that the designed by the destached for the phy		23e. Did tobacco use contribute to	_
Division of Vital Records, P.O. Boy To the Hospital or Attending Physician: The law requires that the deatt within 24 hours after death. To the Funeral Director: After this certificate has been signed by the att completely filled in by the funeral director, page 2 should be detached for			utopsy findings availab completion of cause of es 2 No
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Division or A uns after after in Direction in Eastern i	3 Suicide 6 Could not be determined (Specify) Multi-Family Apt.	or Town, State)  24 N Carey Street #2R, Baltimore	
Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the fooding			
To the He within 24 To the Fa	and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.	29d. Date signed (Mo May 22, 2012	
2	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MI	D 21223	

State 31. Date filed (Month, Day, Year)
Registrar JIN 0 1 2012

32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 31°, 2012 William E. Robbins 1:26 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 10830 Margate Road Silver Spring If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 233-32-4568 1 🛛 M 2 🗆 F Usual Residence of Decedent 88 July 20, 1923 West Virginia 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗌 Yes 2 🏻 No Montgomery MD Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 10830 Margate Road 20901 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: Completed Year or Dates. 1941-45 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) U.S. Department College (1-4 or 5+) Elementary/Secondary (0-12) 5+ of Agriculture Entomologist 1 and 2 should be filed w if Health and Mental Hyg item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Russell Earle Robbins Martha Ringel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10830 Margate Rd. Silver Spring, MD 20901 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i <u>Pamela Robbins / Daughter</u> injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/1/2012 Woodbine, Maryland of Funeral Service Lice 21. Signat Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician. Atherosclerotic Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consuluence of Examin and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ f in the past 12 months? Month Day Pregnant at time of death Year ed by the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires been si Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has s certificate has director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident
Suicide n 24 hours after death.

e Funeral Director: A pletely filled in by the fu Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Hospital Medical 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the Complet only one 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jéanne P. Asher, M.D.

31. Date filed (Month, Day, Year)

JUN 0 1 2012

D34032

3720 Farragut Ave Kensington, MD 20895

29d. Date signed (Month, Day, Year)

May 31, 2012

arturo Mercado		1- For State Registrar	tate of Maryla		artment o <i>rtificate o</i>		na Meni		Reg. N	o. 20	12 1733
Physici Medical Exami		Decedent's Name (First, Midd						Mont		y Year	3. Time of Death 0305 hrs
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		Montgomery General	Hospital			Olney				Montgomen	/
Funeral Director		5. Social Security Number 558-33-4202	6. <b>S</b> ex	7. Age (In yrs.   49	ast birthday) Yr:		ear If Unde ays Hours	Min	e of Birth(M -4–196	For	Birthplace (State or eignPhillippines Country)
any		Usual Residence of Decedent  10a. State 10b. County		I10c City	. Town or Loca	tion					10d. Inside City Limits
<b>*</b>	tor	MD Mon	tgomery	,	kville				1 : :-		1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	13800 Lionel	Lane			10f. Zip Code 20853			1 -	citizen of What C nited Sta	•
death or iter	/ Funeral	11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Dir	Armed Formal 1 X Yes vorced If Yes, Give Yea	2 No	lf )	as Decedent of Hores, specify Cub	an, Mexican,	in? ( Specify Ye Puerto Rican, e	s or No- tc.)	White, etc	erican Indian, Black, sian
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1215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examinec.	Completed	Elementary/Secondary (0-12)		-4 or 5+)	11.70.2	nost of working li ware Eng		use retired)	T.	formati	on Technology
5-00% led with: Hygiene, other ti	E	17. Father's Name (First, Middle	4 a, Last)		3011	ware ch		s Name (First, M			on recimeros,
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Federico V. F	Recio		ALUMATURE NEW		Loli	ta G. M	ercad	0	
D hou nd hou a si si si si si si si si si si si si si	ဥ	19a. Informant's Name/Relations Angela W. Rec			19b. Mailin	g Address (Str Lionel	eet and Num Lane,	ber or Rural Rou Rockvi	ite Number, 11e,	city or Town, St Maryland	ate, Zip Code) 20852
ore, MEss I and 2 soft Health a Litem 27		20a. Method of Disposition  1 X Burial 2 Crematio	n 3 Removal fro		Place of Dispo: crematory or of	sition (Name of o ther place)	emetery,	Date	20	c. Location - City	
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other S	pecify:	No		lem Park		6-2-201			, Maryland
Baltimore permit. Pages I Department of I Important: If injury or other		21. Signature of Funeral Service	Juli	n Deibl V	CI I	Name and Addre .70 Rock				y-Goldhe 11e, Mar	y1and 20852
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the death	. Do not enter t	the mode of dyin	g, such as ca	ardiac or respirat	ory arrest, s	shock, or heart	Approximate Interval Between Onset and
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		Sequentially list conditions,	b. Atheroscler		*	ease					
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D. BC t the dea by the a	Phy	Part II. Other significant condi	9 Onkiro		esulting in the	underlying cause	given in Par	rt I 23e	. Did tobaco	co use contribute	to the cause of death?
i, P.O.	ē						g			_	robably 4 🗹 Unknown
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tal Rec cian: The certificate ector, page	Bec	25. Was case referred to medica				26.Pla	ce of Death (	Check only one)		1 💇	100 2 100
of Vitaing Physici	<b>B</b> 0	examiner? 1 ✓ Yes 2 No		npatient 2 🗸				Nursing Home		dence 6 Ot	her:
_ = # _ < ₽	<u></u>	27. Manner of Death  1 ✓ Natural 5 Pen	28a. Date (Month)	of Injury , Day,Year)	28b. Time of	′′′   _	jury at Work? Yes 2		scribe how i	njury occurred	
Vision or Attene frer death Director: in by the	ertification	2 Accident Inve	stigation	e of Injury - At h	ome, farm, stre	et, factory, office		c. 28f. Loc	ation (Stree		Rural Route Number, City
ospital bours a meral j	Cert	4 Homicide	ermined (Specify)								
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Exa	hysician: To the bes aminer: On the basis of and manner s	of examination a	_						
	Σ	29b. Signature and title of certific					.M.E.			d. Date signed (# ay 29, 2012	Month, Day, Year)
THE		30. Name and address of persor	Mulac v	se of death (Item	1 23a)		¢.1¥1. ∟.		IVI	a, 20, 2012	
2 D.		Carol H. Allan, MD	Assistant Medic		•	Baltimore St	reet, Balti	more, MD 2	1223		
St Regis	ate trar	31. Date filed (Month, Day Year)	2012 22 Re	gistrar's Signatu	bar	Kel					

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month Michael Ernest Roth May 5:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1640 Williams Avenue Baltimore Essex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Days Months Hours Min. Director 165-22-0950 Usual Residence of Decedent 1 X M 2 □ F Yrs 12/2/1927 Pennsylvania 84 or then "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1640 Williams Avenue 21221 S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. Š 1 Never Married 2 M Married 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Carpenter Home Building Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Samuel Anna Mary Jurgosky Pege 1 end 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace E. Roth (Wife) 1640 Williams Avenue Essex, Maryland 21221 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pege Depertment o Important: If any injury or once. ò 1 XBurial 2 Cremation 3 Removal from State 261<sub>2</sub> 4 Donation 5 Other (Specify) Gardens of Faith Mem. Gard. Overlea, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, 52 Maryland 21221 at used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physicien and if for use es the burlel-transit Cause (Disease or mjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physicien: The lew requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death cate hes been signed by the cate hege 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?. Completed by of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate funerel director, peg 1 Yes 2 No ☐ Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Tes No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fune 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical (Check only one)

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(Check one) Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated leted cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Registrar

JUN 0 1

Ron

State

X

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

D27301

Douglas Shumaker 615 West Montgomery Avenue, Rockville, Maryland 20850

May 29, 2012

	1	For State of Maryland / Department of Health State Of Maryland / Department of Health Certificate of Deat			2016	17340
6. A. A.S		Registrar Certificate Of Death  1. Decedent's Name (First, Middle, Last)		. Date of Dea	Reg. No.	3. Time of Death
Physician	n	David Byron Small	i-	Month	Day Year	0852 M
/Medical	-	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locatio	100	<u> </u>	4c. County of Dea	
			nore			
Funeral		1M 2 F A Q Months Days Hours	ler 24 Hrs. 8. s Min.	Date of Birth (Month, Day	y, Year) 9. Bir	thplace (State or Foreign ountry)
	-	217-64-1986	L	July 26	5, 1963 l	/aryland
yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
a-1 st	2	Maryland Baltimore Parkville	е			1 ☐ Yes 2 No
or 28	2	10e. Street and Number 10f. Zip Code		1	10g. Citizen of What C	*
iffer death with the Maryland rifeme 23a or 28a-1 show niner must be notified at	2	8314 Nunley Drive, Apt A 2123				es of America
fier de	5	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2/2/2No	can, Puerto Ric	can, etc.)	Black, Whi	
5-0036 72 hours after natural, or its diseal Examina	2	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ZXXNo 3 ☐ Widowed 4 ☒ Divorced Year or Dates: 1 ☐ Yes 2XXNo Specified Specifi	ify:		Specify: Wh	ite
21215-0036 ed within 72 hours after death with the Marylan ygiene. Then "natural", or iteme 23e or 28e-1 show it. The Medical Examiner must be notified at the model of the completed by Eurors in Director	nere	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during m	ost of working		16b. Kind of Business	/Industry
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nd 2	2	12	ther's Name (F	First, Middle,	Maiden Sumame)	
(T) = 8 = 5 = 10	0	Byron Lee Small	Pa	atricia	a Faust	
2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num	nber or Rural F	Route Number	r, City or Town, State,	Zip Code)
Iore, Maryla ges 1 and 2 should t of Health and Men if from 27 is marks or other treumatic	_	Patricia Klarner - Mother 9008 Throgmorton	the same of the same of	-		
Dores 1 Fitter or out		20a. Method of Disposition  1 □ Burial 2 [XCremation 3 □ Removal from State]  20b. Place of Disposition (Name of Disposition (Name of Disposition))	Dat		20c. Location - City of	
Baltimor permit. Pages Department of I Importent: If Its Importent: If Its		4 Donation 5 Other (Specify) Cremation Services—BelAir 21. Signature of Funeral Service Licensee 22. Name and Address of Eac	-			
Balt permit. Depart Import any injury once.	1	Stace of Spain Evans Funeral Ch 8800 Harford Roa	d, Parkv	ille, M	aryland 212	
£		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	as cardiac or r	espiratory arr	rest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a	mhol	i Snz		
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	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				1
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50, be exected a		resulting in death) Last Due to (or as a consequence of):				
68760, ifficate be executed g-physicien and as the burial-transit		d				
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IS, P.O. Box of the strength o	200	in the past 12 months?  1  Yes 2 2 No  4  Pregnant at time of death 5 Other (specify)			Month	Day Year
P.O hat the detache detache	Ě	a □ ∩ukuowu		00. 5:11		
	'n	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	irt I.		obacco use contribute ( es 2 2 No 3 F	robably 4 Unknown
Cord  **requir  **peen si  **should	ונו	Branchitis		24a. Was a		utopsy findings available
II Record The law requires the law requirements that the law requirements the law requirements that the law requirements that the law requirements the law requirements the law requirements that the law requirements the law require	4			autop: perfor	rmed? prior to death?	completion of cause of
Vital Fician: The certificate rector, page	3)	25. Was case referred to medical 26. Pts	ace of Death (	-	2 ØNo 1 ☐ Ye	s 2 DNo
- × × 5	<b>O</b>	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4	Nursing Home	5 Resid	dence 6 □Other (Sp.	ecify)
ding P	5	27. Mann of Death 1 ✓ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work?		d. Describe h	now injury occurred	
isic ittend death ctor:/ the f	200	2 Accident investigation 3 Suicide 6 Could not be determined determined.		f Location /S	Street and Number or F	Rural Route Number
Division (  Ital or Attending F  is after death.  al Director: After ied in by the funer.  Contification.		4 Homicide determined building, etc. (Specify)		City or Tow		a.a. ribato ribilibat,
Division or To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification.		29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, or and manner stated.	and place, and death occurred	d due to the o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the To the Complex	3	29b. Signature and title of certifier 19 29c. License number	er	-	29d. Date signed (Mor	ith, Day, Year)
		D3€	543		May 3	0,2012
9.1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	10.00	1 72	16 -	1, 21239
1 1		Win 1. Scruggs (us) Good Samar, faur to 31. Date filed (Month, Day, Year)  JUN 0 1 2012  Date filed (Month, Day, Year)  JUN 0 1 2012	Tus pe te	1 Ph	-ctucoil,	mary ford
State Registrar		JUN 0 1 2012 Come B. park				*

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CTRICKER Physician/ CHARLES EDWIN 9:15 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SAMARITAN HOSPITAL BAUIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 216-20-7471 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 1 № M 2 🗆 F Baltimore, MD 28 06 Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 902 Huntsman Road 21286 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 Widowed 4X Divorced WWII Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Sun Computer Programmer 11 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 rmit. Page 1 and 2 should be 1 partment of Health and Menta portant; If item 27 is marked y injury or other traumatic ev George C. Stricker Ola Plumbhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Stricker-Brother 3406 E. Joppa Road Carney, MD 21234 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State June Parkville, MD Parkwood Cemetery 4 Donation 5 Other (Specify) 2012 Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ARDIORESPIRATORY ARREST Physician/ ease or condition resulting in death) Medical **Examiner** BRONCHIAL OBLITERATING ORGANIZING PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Exami Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 attending for use as JÉ FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 1 Yes 2 1 Unknown 9 Unknown ed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by C. DIFFICILE INFECTION, ADRTIC STENOSIS WITH Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown MECHANICAL AORTIC VALVE REPLACEMENT, ATRIAL Were autopsy findings available prior to completion of cause of AKI AND CKD death? FIBRILLATION certificate | 1 Yes 2 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide the Funeral Director; Anpletely filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD RES 000 2x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BLVD. BALTIMORE MD 5601 PANA RAY

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Anne Marie Skille May 2012 7:00P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign. Day, Yea 1 🗆 M 2 🔀 F 79 New York, New York 054-26-0614 Yrs Director September 29,1932 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Parkville 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 8810 Walther Blvd. Apt. 3514 21234 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 an "natural", o 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Clerical St. Joseph Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edmund Dowdall Marquerite Duffe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Diane Skille (Daughter) 9101 B. Lincolnshire Court Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State June 04,2012 Parkville, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service Licensee Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Mail Approximate Interval Between Onset and Death Physician/ Waenocarcinoma. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examin sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day d ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 🗌 Yeş Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: ဂ္ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 15N R171944 5/30/2012 12) (Type, Print) 8800 Walther Blvd, Parkville MD 2/234 CLUP MSN eted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

5/30/2012

akar Smith		State of Maryland / Departr	ment of Health and Mental H cate of Death	łygiene	201	2 1734
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)	cate of Death	Re 2. Date of Deat	g. No.	3. Time of Death
ledical Exami		201101	mith	Month May 22, 20	Day Year 012	0406 hrs
		Facility Name (if not institution, give street and number)     University Hospital	4b. City, Town, or Location of Dea Baltimore	h	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		s. 8. Date of Birt	h (MM/DD/YYYY) 9. Birl	
Director		12M 2 F	Yrs. Months Days Hours Mi	4/13	PAL2 Foreig	n untry) Marulana
any		Usual Residence of Decedent  10a. State 10b. County 10c, City, Tow	n or Location			10d, Inside City Limits
	_	MD Baltimore	Randallatown			1 Yes 2 No
Aaryland 28a-f show 1 at once	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.		8709 Stephanie Road	21133		USA	
ath wil	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? ( § If Yes, specify Cuban, Mexican, Puert		14. Race - Ameri White, etc.	can Indian, Black,
fter de I", or i		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:		Specify: R	look
nours a	ed by	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/I	ndustry
36 iin 72 l	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Manage Notice	(, )	N.I.	A
5-0036 iled within 72 Hygiene. I other than	Som	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, M	aiden Surname)	
21215 ould be file Mental H marked c event, t	Be	L Shawn Smith	Jah	aan	Shiher	d
and Sho	ဥ	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or	Rural Route Numl	per, City or Town, State,	Zip Code)
<b>~</b> 말등 등 등			of Disposition (Name of cemetery,	Date Date	20c. Location - City or	Town, State
<b>2</b>		1 VBurial 2 Cremation 3 Removal from State Crem: 4 Donation 5 Other Specify:	Zion Cemetra 6	1/10	100000	ne MD
Baltimo permit. Page Department Important: injury or ot		21. Sonalure of Funeral Service Licer	22. Name and Address of Fadility	Funer	of Home, Pa	
	1/4	23a. Part. Eyer the disease, of complications that caused the death. Do	12222 W. North	AVI. D	alto Mo	21016
Physician /Mgaical		failure. List only one cause on each line.			st, shock, or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Sudden Unexplain  Due to (or as a consequence of):	ned Death In Infancy	(SUDI)		
	ē	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	miner	Course Chief Underlying Cause C. (Disease or injury that initiated			14	
uted 1d ransit	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.				
D, be executed sician and surial - trans	dical	▼ UNPENDED	-f,per me,g929 7-30-	2 sm		
68760 certificate I nding phys	w	IF FEMALE: 23b. Was decedent pregnant in the  23c. If yes, outcome of pregnance 1 Live birth		anov.	23d. Date of delivery Month D	Van-
X = 2 - 1	iclai	past 12 months?	2 Fetal death 3 Ectopic pregn 5 Other (Specify)	aricy	I Worth D	ay <b>Ye</b> ar
b. Bo the deat	Physiclan/M	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Port I	23e Did tob	acco use contribute to t	ha cause of death?
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rds,	letec			24a. Was ar		opsy findings available ompletion of cause of
Division of Vital Records, tat or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the contractions of the funeral director.	Completed			perform	ned? death?	,
Vital Rec yrician: The his certificate director, page	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check			
Physic Physic er this	리	1 Yes 2 No Puspital 1 Inpatient 2 V ER/C	Outpatient 3 DOA Other Nursing Time of Injury 28c. Injury at Work?	ng Home 5 R	esidence 6 Other:	
ion of tending Pheath.  Ior: After the funeral	Ē	1 Natural 5 Pending Fd 5-22-12 Fd	1 3:00 am	unknown	w injury occurred	
ViSion Atte	Certification:	2 Accident investigation	farm, street, factory, office building, etc.		reet and Number or Run	
Dispital hours a hours a filled y	S	4 Homicide determined (Specify) Found: Res	idence	520 Balt	te)1100 Bolto imore,MD.	n St.Apt
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Certifying Physician: To the best of my knowledge, de (Check only one)  2  Medical Examiner: On the basis of examination and/or				
To vitil	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
		his wis	O.C.M.E.		May 23, 2012	
and	Ì	30. Name and address of person who completed cause of death (Item 23a)		222		
	ate	Ling Li, MD Assistant Medical Examiner 900 W. E  31. Date filed (Month, Day, Year)    32. Registrar's Signapure	<del></del>			
Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Doris Klein Silverman 12:24 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chevy Chase Montgomery 8809 Montgomery Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Days Min (Month, Day, Year) **Director** 578-46-6429 1 □ M 2X F 95 11-17-1916 New York Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Chevy Chase Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8809 Montgomery Avenue 20815 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc 1 Yes 2 X No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be filed ment of Health and Mental H tant: If item 27 is marked ot Benjamin Klein Ethel Cohen other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda S. Herman - Daughter 7100 Glenbrook Rd., Bethesda, Maryland 20814 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Garden Of Remembrance 5-30-2012 4 ☐ Donation 5 ☐ Other (Specify) Clarksburg, Maryland Signature of Funeral Service Licensee Brad Smetzer 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Aortic Stenosis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last g physician and as the burial-trans Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2X No Month Day Year Pregnant at time of death Unknown 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director; After this certifies filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred XNatural injury work?
1 Yes 2 No 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8218

Registrar's Signatu

Ava Kaufman, MD

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Wisconsin Avenue, Bethesda, Maryland 20814

D26259

29d. Date signed (Month, Day, Year)

5-29-2012

amend 20b, per fh, g928 6-5-12 sm
Please Type or Print in Black Indelible ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Steinke James 28 Emerson May 04:50p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 3102 Juneau P1ace Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/28/1955 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min. Hours XX M 2 X Director 497-60-8314 TX 57 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Washington DC N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20024 1250 4th St. SW Apt. W506 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?
1 X Yes 2 □ No Black White etc. Completed by 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 If Yes, Give 1980–2005 Year or Dates 1980–2005 1 Yes 2 X No Specify: If Yes Give 3 Widowed 4 X Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Defense Civil Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MacDonald Mary Jean Clifford Hobbs James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Hollen Road, Baltimore, MD 21212 Mary E. Steinke, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 8/23/2012 Arlington National Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dea Immediate Cause (Final Ph. i. i. n disease or condition POUT Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 SE IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed' Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Friend's Hospital 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA residence Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred I Director: After to ad in by the funera 28b. Time of 28c. Injury at work? Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier and title of certifier 29d. Date signed (Month, Day, Year) 20+1 address of person who completed cause of death (Item 23a) (Type, Print) SD9 South 31. Date filed (Month, Day, Year) 32. Registrar's Signature **State** Registrar

	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Per No. 2012 17346											
			Registrar  1. Decedent's Name (First, Middle, Last)	Cerui	ICale OI L	)taui	2. Date of De	Reg. No.	2011	3. Time		
	Physicia Medic		Marian Sheskin				Month 5	24 24	2 <sup>Year</sup> 1			
	Examin		4a. Facility Name (if not institution, give street and number)		b. City, Town, or		eath		County of Dea			
	Euporal	-	9600 Merwood Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birtl		Silver fUnder 1 Year	Spring	dre la Data at Dia		ntgome			
	Funeral Director		579-16-3715 June 7 92		onths Days		lin. (Month, Da	y, Year)	Co	thplace (State untry)	or Foreign	
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	the Ma or 28 e noti	قِّا	10e. Street and Number		10f. Zip Code			10a. Citiz	zen of What Co		S Z LZMNO	
	s 23a	Funeral Director	9600 Merwood Lane	_	20901				ted St			
	death r item iner n	F	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1  Yes 2 X No	13. Was	Decedent of His	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	1	4. Race - Ame			
920	s after al", o Exam	d b	1 Never Married 2 Married 3 Widowed 4 Divorced  1 Yes 2 No If Yes, Give Year or Dates,		Yes 2 X No			Black, White.			- 0	
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/lan	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	은	Steven Finkelstein				nces (UnK		,			
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e,	and 2 Health em 2; ther t		Gene Sheskin - Son 48  20a. Method of Disposition 20b. Place of			Dr., F	Rockville					
mor	age 1 ent of nt; If ii		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	ry, cremato	ry or other place		Date 5-29-2012		ation - City or			
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee Edward Sage1								ion	
_	1091 Rockville Pike, ROckville, Man										852	
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ot enter the	e mode of dying	, such as cardi	iac or respiratory an	est,		Approxima Interval Be	tween	
)	Phylician Medical		disease or condition resulting in death)  Due to (or as a consequence of	of):						Hours	Death	
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	ecute and Il-trans	Exan	Cause (Disease or injury that initiated events c	ofi:								
09	death certificate be executed re attending physician and ed for use as the burial-transit	dical Examiner	C <sub>d</sub>	,								
6876		Med	IF FEMALE:									
×6	ith cer itendii	ian/	23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 \subseteq Live Birth 2 \subseteq Fetal death		topic pregnancy	,		23	3d. Date of del	-		
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rds,	equires sen sig nould b						_ 1 🗆 '	res 2 🛚	No 3□Pr	robably 4 🗆	Unknown	
00 00 00	The law re ate has be page 2 sh	Completed					24a. Was autop	sy		opsy findings completion of	available cause of	
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ion	ttendi death. :tor: A / the fu	Certificate:	2 Accident Investigation		√ 1 □ Y	′es 2 □ No						
Division of Vital Records,	al or Attending P s after death. Il Director: After t ad in by the funer:		4 ☐ Hornicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	m, street, f	actory, office		28f. Location (S City or Tow		Vumber or Run	al Route Numi	ber;	
ш	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifler  1 X Certifying Physician: To the best of my knowledge, di (Check 2 ☐ Medical Examiner: On the basis of examination and/or	leath occur	rred at the time,	date and place	e, and due to the ca	use(s) and	manner as sta	ated.		
	the H thin 24 the F mplete	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowl	investigation ledge, deat	th occurred at the	e time, date and	d place, and due to the	ne cause(s)	and manner as	s stated.	anner stated.	
	5 W 5 00		29b. Signature and title of certifier	. //	D3315				signed (Month) -24-20]			
	1/100		30. Name and address of person who completed cause of death (Item 23a) (Ty		<u> </u>							
	1,0		Ruth Keuess Cohen, MD - 8700 Georg	gia A	venue, 1	400, S	Silver Spi	ing,	Mary1a	and 209	10	
	State Registra	-	31. Date filed (Month, Day, Year)  JUN 0 1 2012  32. Registrar's Signature	park								
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			For State	State of M	aryland		irtment of F <i>tificate of D</i>	lealth and N	/lental Hy	giene <sub>Reg. No.</sub> 2 (	112	17347	
			Registrar  1. Decedent's Name (First, Middle,	Last)		Cer	uncate of L	reau i	2. Date of De		J   L	3. Time of Death	
	Physicia Medic		Dorothy Shapiro	)					Month 5	2 <sup>3</sup> 9	2012	5:50 P M	
-	Examin		4a. Facility Name (if not institution,	give street and number)				Location of Death		4c. County		_	
orc's	Funeral		Manor Care  5. Social Security Number	S. Sex 7. Ag	e (In yrs. Ia:	st birthday)	Potoma If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	1	gomer	y place (State or Foreign	
	Director		050-18-7861	1 □ M 2 🕅 F	90	Yrs.	Months Days	Hours Min.	(Month, Da 12-6-1	y, Year)	Ore	try)	
	nd how at	្ក	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation		12 0 1			0d. Inside City Limits	
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	h the la or 2 be no	al Di	10e. Street and Number				10f. Zip Code		I	10g. Citizen of		-	
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and	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, La	st)				18. Mother's Nam			e)		
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saitimore,	e 1 an t of He If item or othe		20a. Method of Disposition  1 X Burial 2 Cremation	Bemoval from State		ace of Dispos metery, crem	ition (Name of atory or other place	∌)	Date	20c. Location	- City or To	wn, State	
E	it. Pag rtment rtant: ıjury o		4 Donation 5 Other (Sp	ecify)	King		Mem Gdn					, Virginia	
g	Morris Marcys  19a. Informant's Name/Relationship (Type, Print)  Stuart Goldman— Gaurdian  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19b. Mailing Address (S											and 20852	
23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate		
Immediate Cause (Final disease or condition Cerebrovascular Accident										Interval Between Onset and Death 2 month			
	Medical Examiner	Due to (or as a consequence of):											
d	-9	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):					-		
	outed nd transit	kami	Cause (Disease or injury that initiated events	C							- 22		
_	sate be executed physician and the burial-transit	edical Examiner	resulting in death) Last	Due to (or as	a conseque	ence of):							
20	icate by physics the l			d									
DOX DO	h certii tending rr use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth	of pregnan	cy death 3 🗌	Ectopic pregnancy	V		23d. Da	ate of delive	ry	
0	e deat the att	ysici	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 Pregnant a 9 Unknown	t time of de	eath 5	Other (specify)			Mo	onth	Day Year	
	that the	by Ph	Part II. Other significant condition	s contributing to death b	ut not resu	Iting in the un	derlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to the	e cause of death?	
S,	quires an sign	q pa	Ischemic cardi	omyopathy					1 🗆 '	Yes 2 XNo	3 🗌 Prob	ably 4 🗌 Unknown	
Records,	law rec	Completed	Hypertension						24a. Was	osy		sy findings available npletion of cause of	
re	t: The icate h r, page		05 W						perfo	rmed?	death? 1  Yes	2 🗆 No	
N Ka	/siciar s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital:	ant 2 🗆 🗆	R/Outpatient	Othe	r: 4 XNursing Ho		2 C [ ] O#	(0		
5	ng Phy ter thi		27. Manner of Death 1   ↑ Natural 5 □ Pending	28a. Date of inju (Month, Day	ry 2	28b. Time of injury	28c. Injury	at		ow injury occurr			
0	ttendir death. tor; Af the fu	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	tion t be			M 1 □ '	Yes 2 No	_				
DIVISION OF	I or A		4  Homicide determin	ed 28e. Place of Injubulding, etc	iry - At hom :. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rural	Route Number,	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying F	hysician: To the best of	my knowle	dge, death oc	ccurred at the time.	date and place, ar	nd due to the ca	ause(s) and man	ner as state	d.	
	the H thin 24 the Fi	Me	only one) 3 L Certifying N	uminer: On the basis of eaurse Practitioner: To the	e best of my	and/or investig y knowledge, o	death occurred at th	e time, date and pla	ice, and due to t	he cause(s) and r	nanner as st	tated.	
	<b>7</b>		29b. Signature and title of certifier	Masters	/t	MN	29c. License D5053			29d. Date signer 5-30-20		ay, Year)	
	1) Mr		30. Name and address of person wh	o completed cause of d	eath (Item 2	23a) (Type, Pr	int)						
	100		Thomas Masterso	on, MD - 685	58 01	d Domo:	nion Road	1,#104, M	clean,	Virgini	a, 22	101	
	Stat Registra	-	31. Date filed (Month, Day, Year)  JUN 0 1 20	12 Servera	ir's Signatu	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4:23 PM 2. Date of Death Physician/ May Day 9, Gregory Seagle 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours (Monthy Day Year) 1950 215-54-3875 Maryland Director 1 M 2 D F Usual Residence of Dece 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be by Funeral 23a 2013 Oakington St. United States th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4-or 5+) Teacher Towson University Be 17. Father's Name (First, Middle, Last) Department of Health and Mental H Important: If item 27 is marked any injury or -----18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Wilson Seagle Thelma Edler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Taylor /Sister 1824 Edgewood Road Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 31 1 Burial 2 Cremation 3 Removal from State emetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 2012 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Colon disease or condition TYCARI Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant Box ( 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Yes 2 ☐ No ed by the a g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No certificate has Division of Vital filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA hospice 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending work'? 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in proposition death. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MAY 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES 6701 N. Charles M 31. Date filed (Month, Day, Year) 2. Registrar's Signatur State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Paul Т. Skwirut 8:45 P M 30, May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) January 24, 1936 9. Birthplace (State or Foreign **Funeral** Months Maryland 216-30-5687 Director X M 2 □ F 76 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at. 10c, City, Town or Location 10b Count 10d. Inside City Limits Direct Baltimore Dundalk Maryland 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? eral 2233 Searles Road 21222 USA Fun 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Local Union 1383 2 vears Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nieolas Skwirut Anna Wolak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul M. Skwirut son 4115 Halifax Court, Glen Arm, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State June 1,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 21. Signature of Fundral Service License Connectly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Examine Due to (or as a consequence of) ettending physician and for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) ᅙ 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) HOSPICE funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural injury within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Investigation ☐ Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 🖟 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 25<sup>Day</sup> 2012 3:05 PM Margaret Shafer Saunders Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7622 Winterberry Place Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. (Month Day, 184-24-8158 85 1927 Pennsylvania **Director** May Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Tes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 7622 Winterberry Place United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Yes 2 X No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ G. Carlton Shafer Margaret MacIntire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. Saunders, Jr./Husband 7622 Winterberry Place, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 29 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc. 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Years Immediate Cause (Final Physician/ Myelodysplastic Syndrome disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): anding physician and use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 X No for Month Pregnant at time of death signed by the a d be detached for 1 ☐ Yes 2 kg 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a. Was an cate has I page 2 s prior to completion of cause of death? autopsy perform 1 Yes 2 No Yes 2 X No Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifice To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) May 29, 2012 D0033293

Registrar

Frederick P. Smith, MD 5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 8 1223 PM DUIS SCHLOSS MBY 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ENVOY OF PIKESVILLE BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Sex 1X ☐ M 2 ☐ F Min 212-32-5965 75 0671971936 **Director** Usual Residence of Decedent 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 HARTLEY CIRCLE, APT. 835 21117 USA · death v 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. <u></u> 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify. WHITE Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 | and Mental Hygiene. 'is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) EXECUTIVE INSURANCE other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HARLEM. SCHLOSS JANET COOPER f Health and 2 sh. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NINA SCHLOSS/WIFE HARTLEY CIRCLE, APT. 835, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State of 5 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) CARROLL CREMATION INC 05/30/2012 HAMPSTEAD, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. cetto VII 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph, sician/ LEWY ROD! disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown the signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à the Hospital or Attending Physician: The law requires DIABETES. 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed the Funeral Director, After this certificate In pleted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No Other: 9 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 24 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and R085552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith DUSNUE GRETTMAN, C. DIAMOND KATHUSSI State

Registrar DHMH 17 Rev 7/2009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per FH G928 6/05/2012 JH
State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Marylar		tificate of D		-	Reg. No. 2	12	17352			
	Dhusisis	,	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		Year_	3. Time of Death			
	Physicia Medic	al	Frederic Tsai					May	1	2012	5:10 A M			
1	Examin	er	4a. Facility Name (if not institution, give			4b. City, Town, or			4c. County					
-			14800 Pennfield C		last hirthday	Silve:	r Spring If Under 24 Hrs.	8. Date of Bir		g Righton	LY lace (State or Foreign			
	Funeral Director			X M 2 $\square$ F		Months Days Hours Min. (Month, 633 Year)				Counti	ry)			
		Н	Usual Residence of Decedent	62	Yrs.			Jan 3	<del>0</del> , 1950	Chir	na			
	and shov	ē	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10	Od. Inside City Limits			
	Maryl 28a-f tified	rec	MD Montgo	omery		Silver	Spring				1 🗌 Yes 2 🕅 No			
	the l	Ö	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	try?			
	s 23.	Funeral Director	14800 Pennfield (				906		Unite					
	death	Fu	11. Marital Status	<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	.S. 13.	Was Decedent of His f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.					
36	after II", or xami	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify:  3 Widowed 4 No Divorced Service Specify: Specify:							Asi	an				
21215-0036	nours atura	Completed	15. Decedent's E		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Ba					
215	רק 72 ו an "n Medi	dm	(Specify only highest gra	de completed)  College (1-4 or 5+)		kind of work done o O NOT use retired)	luring most of work	ing	· .					
212	withir giene er th		Elementary occorrodry (o 12)	4	Buil	der			Const		.on			
	filed al Hy d oth	o Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surname	1)				
Maryland	ld be Ment arke	욘	Wentchih Tsai				<u>Janet</u>	Wu	<del>.</del>					
<b>Jar</b>	shou and is m		19a. Informant's Name/Relationship (T)			ng Address (Street a								
	and 2 lealth		Janet Tsai / Mot	her		O Pennice  District Particle  Osition (Name of		Date	20c. Location -		y, MD 20906			
Jore	ge 1 and the state of the state		1 Burial 2 K Cremation 3	Removal from State	cemetery, cre	matory or other plac	e)			,				
Baltimore,	it, Pa		4 Donation 5 Other (Specif			ney Cremat		1/2012			Maryland			
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signs the of Funeral Service atoms	tachokeno	)1251 E	oing Home everly L.	Crematic Heckrot	on Serv te, P.A	ice P.O. . Clarks	Box vill∈	784 , MD 21029			
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only o	plications that caused the dea	ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between			
	Physician	١,	Immediate Cause (Final disease or condition		Neopla	sm of the	Pharynx				Onset and Death			
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Malignant Neoplasm of the Pharynx  Due to (or as a consequence of):											
	Examiner	<u>~</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	michae of:					_				
	ed sit	Ē	cause. Enter underlying Cause (Disease or injury	Due to (or as a consec	querice oi).					-1				
	Attending Physician: The law requires that the death certificate be executed by death.  sr death.  ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	that initiated events resulting in death) Last	C. Due to (or as a consec	quence of):									
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3760	ficate g phy as th		IE EENALE.											
, 68	oenti endin r use	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1  Live Birth 2 Fe	nancy tal death 3	Ectopic pregnanc	су			te of delive				
Box	death ne ath ed for	Completed by Physician/M	in the past 12 months?  1  Yes 2 No	4 Pregnant at time of 9 Unknown		Other (specify)			Mo	onth	Day Year			
P.O.	requires that the des been signed by the s should be detached	문	g Unknown  Part II. Other significant conditions of	ontributing to death but not re	esulting in the	underlying cause giv	ven in Part I.	23e Did	tobacco use cont	ribute to th	ne cause of death?			
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rds	equir een s hould	etec						24a. Was	24b	Were auto	psy findings available			
ပ္ပ	law r has b	盲						auto	opsy formed?	prior to col death?	mpletion of cause of			
Ä	r; The icate r; pag		OF Man ages referred to modical			06 D	lace of Death (Chec		2 XNo	1 Yes	2 L No			
ital	siciar certif irecto	Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	7.50(0.44)	_ Oth	or:		idence 6 🗆 Oth	or (Coooih	A			
of Vital Records,	Phys r this eral di	은	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	of 28c. Injur	y at		how injury occur		<i>/</i>			
n o	Attending P death. ctor: After toy the funeral	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Day, Year)	injury	M 1 🗆	<br   Yes 2 □ No							
Division	Atter	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	De 28e Place of Injury - At I		reet, factory, office			(Street and Numb	er or Rural	l Route Number,			
≥	ital or irs afte al Dir led in													
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	Chock 2 Medical Evan	sician: To the best of my kno- niner: On the basis of examinationse Practitioner: To the best of	ion and/or inve	stigation, in my opini	on, death occurred a	at the time, date	and place, and du	ie to the cai	use(s) and manner stated.			
	To the within 2 To the comple	2	29b. Signature and title of certifier		,	29c. Licens			29d. Date signe					
			16	eeV		D	37142		May	30,	2012			
	•		30. Name and address of person who			Print)	leville M	ID 200E0	1					
	Sta	10	Geoffrey Coleman 31. Date filed (Month, Day, Year)	1, M.D. 1355 32. Registrar's Sign		d Dr. Roc	varite' M	الاوماد س	,					
	Registi		JUN 0 1 2012	Zena D. A.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b, perFH, G928, 6/1/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edward May 28ª 2012 Harry Thorpe 06:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harford Havre de Grace . Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Birthpu Country) NC Months Davs Hours  $12^{(Month, Day, Year)}$ 228-28-1941 83 Director Usual Residence of Decedent 28a-f show 10b. County Cecil 10a. State filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Port Deposit Port Deposit 1 ☐ Yes 🏋 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 271 Arthur Avenue 21904 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. African by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: American Completed Il Hygiene.
I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Postal Service Ith and Mental Hygier 27 is marked other t r traumatic event, the 10th Grade NΑ Be 18. Mother's Name (First, Middle, Maiden Sumame)
Maguria Allen 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important. If item 27 is marked of any injury or other traumatic eve ပ Lazarus Thorpe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Thorpe-Son 271 Arthur Avenue Port Deposit, Maryland 21904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Vernon Hill Bapt. 06-09-12 Person County, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Ture of Funeral Service Licenses 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup> Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) encephaltialh Medical Examiner acute rena Sequentially list conditions Physician/Medical Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Month Year 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 2 No Other: ြု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred **√**Natural (Month, Day, Year) 5 Pending work? ☐ Accident ☐ Suicide 1 Yes 2 No after death Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier P 29c. License number 29d. Date signed (Month, Day, Year) DO064015 28/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Evonne Druelson 201 Hurre de grace SouthUrin wenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 28 GLENA M. THORNTON 2012 12:33 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3701 DONNELL DRIVE FORESTVILLE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Min 246-90-5226 62 Director 1 🗆 M 2 💢 F MAY 18, 1950 NC Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Yes 2 No PG MD FORESTVILLE 10e Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 3701 DONNELL DRIVE 20747 IIS "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ ☐ Yes 2🏋 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life\_DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) ĝ. ADMINISTRATIVE ASSISTANT GOVERNMENT event, th Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed trent of Health and Mental H rtant: If item 27 is marked otl njury or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) 0 LEON THORNTON DOROTHY BELLAMY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REBECCA T. WHITAKER/SISTER 7612 QUINN SPRING CT., HYATTSVILLE, MD 20783 Department of Health Important: If item 27 any injury or other to once. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date FORTETY CEMETERY Or other place)
CEMETERY 6-1-2012 BRENTWOOD, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses M00981 22. Name and Address of Facility POPE FUNERAL HOMES, Charles 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ations that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition HEART FAILURE Medical resulting in death) Due to (or as a consequence of Examiner METASTATIC CANCER OF SUBMANDIBULAR GLAND Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last ATRIAL FIBRILLATION the burial-trar Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð should be 1 Yes 2 XNo 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 Yes 2 X No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ဂ္ 2 No 1 XYes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 🛚 Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MD037655

State

Registrar
DHMH 17 Rev 06-2011

M.D. 110 IRVING STREET, WASHINGTON DC, NW 20010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRING VEYTSMAN,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 29, Physician/ Linda Gail Tharp 2012 11:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 2 If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 055-42-3442 **Director** 1 □ M 2 🛣 F 60 June 11, 1951 New York or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20876 1 Tall Cedar Court United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 M Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 🗌 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Manager Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arnold Paley Dorothy Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Lee Tharp / Husband 1 Tall Cedar Court, Germantown, Maryland 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden Of Rememberance June 1, 2012 Clarksburg, Maryland 21. Signature a Fungral Seque censee

M01619

22. Name and Address of Facility
Robert A. Pumphrey Funeral H
300 W. Montgomery Avenue, Ro

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Phy\_ician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Lat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Keto acidosis Hospital or Attending Physician: The law requires that the death certificate be executed 10 physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the a ld be detached f 9 Unknown g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🔀 No. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA s after dean.
ral Director: After ton-28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined 24 hours at Funeral D etely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) May 30, 2012 D0064507 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Lockville, Mayind 20850 Carpenter, MD 9901 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 26, Franklin Taplin 2012 2:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours 032-09-3826 Director 1 🛛 M 2 🗆 F 92 July 28, 1919 Massachusetts Usual Residence of Deceden 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Mass. Hampshire South Hadley 10e. Street and Number ö 10f Zin Code 10g. Citizen of What Country? 23a ( Funeral 20 Bayon Drive 01075 United States ritems 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married 9 þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WWII If Yes, Give White "natural" 3 X Widowed 4 Divorced Specify. Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. College (1-4 or 5+) 5+ life. DO NOT use retired) Elementary/Secondary (0-12) Library Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Hood Harry Taplin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl tment of Health a item 27 Victoria Taplin Delancy/Daughter 4120 Leland Street, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12, June Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Wellesley, Mass. Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Willia M01173 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Syncope disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Severe Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter enderlying Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Asystole and for use as the burial-tran Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Yes 2 No detached Unknown 9 Unknown ģ been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2 No 1 Yes 2 X No or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 1 🗌 Yes Other: 2 X No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending within 24 hours after death.

To the Funeral Director: At 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

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ess of person who completed cause of death (Item 23a) (Type, Print)

Sudarshan Siva, M.D.

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31. Date filed Monti

1065312

8600 Old Georgetown Road, Bethesda, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ iaht Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner 1ali If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birtholace (State or Foreign Social Security Numbe 7. Age (In vrs. last birthday **Funeral** (Month, Day, Year) 5V. 19, 1944 Hours Min 1**2** M 2 □ F 67 Yrs. Havana 340-52-7954 Cuba Director Nov. Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Baltimore 1 X Yes 2 No Maryland Baltimore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ō 21215 Funeral 5252 St. Charles Avenue items 23a Cuba death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. 5 1 Never Married 2 Married þ should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or Baltimore, Maryland 21215-0036 Cuban 1XXYes 2 □ No Specify: Cuban If Yes, Give Specify 3 Widowed 4XXDivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Technician Electronics 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Clara Esther Cabrisses Enrique M. Valdes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Viviana Valdes/ sister 8512 N.W. 8th Street Miami, Florida 33126 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition June I, cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 1 Burial 2XXCremation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 2012 Fugeral Service Li Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a con equence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events are lifting doubt). Examine Due to for as a consequence of, burial-transit or Attending Physician: The law requires that the death certificate be executed after death. and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 2 No been signed by the should be detached g 🗌 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should ! 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy this certificate has performed Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other 24 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျပ Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Natural
Accident 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work' 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) and little of certifie 29b. Signature 150259

State Registrar Eme

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of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 3 Tay 20<sup>Year</sup>2 Helen Vaughn Α. 12:59A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 94 004-07-8053 Director 1 □ M 2XX June 2,1917 Maine Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Harford Abingdon Maryland 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 3535 Woodsdale Road United States of America 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3XXWidowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "na any injury or other traumatic even." 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Fuel Oil Company Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Sotman Julia Kauneckaite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Lightsey - Daughter 3535 Woodsdale Road, Abingdon, Maryland 21009 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Funeral Chapel and Cremation Services Belair June 1, 2012 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup>
Evans Funeral Chapel and Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Day page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 🗌 Yes 2 🗆 No Yes completely filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 K Other (Specify) مِ| 1 🗆 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending \_\_\_\_\_atural

Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the within 2 3 🗶 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year, State Registrar

12-04077 Lonnie White

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012		7	3	5	5
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		1- For State Registrar	Cen	tificate of i	Death		Re	eg. No.			
Physici		Decedent's Name (First, Middle,Last)	Month Day Year								
ledical Exam	ıner	Lonnie David Whi					May 29, 2	012	1630 hrs		
		4a. Facility Name (if not institution, give street a 510 Xenia Avenue	and number)		. City, Town, or Capitol Heig		ith	4c. County of Prince Ge			
Funeral		Social Security Number     6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year		_		9. Birthplace (State or		
Director		386-46-0016 1 XM 2	]F 6	55 Yrs.	Months Days	s Hours M	in. May 8	, 1947	Foreign Country) Michigan		
any		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location	1				10d. Inside City Limits		
. ≜									1XX Yes 2 No		
Aaryland 28a-f shnw 1.at once	효	MD Prince Geo:  10e. Street and Number	rge's  Ca	pitol H	eights 10f. Zip Code		14	0g. Citizen of Wha			
5-0036  ed within 72 hours after death with the Maryland stygiene and other than "natural", or items 23a nr 28a-f shu the Medical Examiner must be notified at once	Director					40	.		( Country ?		
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eath wi items	Funeral	I Litevel Mailled 2 Walled	ned Forces? Yes 2 No		s, specify Cuban			White,			
ifter d	by Fi	3 X Widowed 4 Divorced If Yes, 61		1 \	es 2 XX No	specify:		Specify:	White		
ours a atura xami	g p	15. Decedent's Education (Specify only higher	st grade completed)	16a. Decedent's	Usual Occupat t of working life.			16b. Kind of Busi	ness/Industry		
5-0036 lied within 72 hou Hygiene. I other than "nat	Completed	Elementary/Secondary (0-12) Coll	ege (1-4 or 5+)	during mos	t of working me.	DO NOT use it	stired)				
15-0036 filed within 72 Hygiene. d other than '	Ę	8th	Ø	Disa			/F1 4 46 1 11 1		isabled		
	Be C	17. Father's Name (First, Middle, Last) Floyd White					ne (First, Middle, M				
2121; and be fil Mental F marked c event, i	To B	19a. Informant's Name/Relationship (Type, Prin	t )	19b. Mailing A	Address (Street		gie Mae Rural Route Num	wells ber, City or Town,	State, Zip Code)		
MD d 2 sho lith and n 27 is		Maurice G. White/Son		9431	Madison	Avenue	, Laure	1, MD 2	0723		
		20a. Method of Disposition		lace of Disposition	on (Name of cen		Date		City or Town, State		
Baltimore, lemit. Pages I and Department of Heal important: If iter injury or other tra		1 Burial 2 X Cremation 3 Remo	Svai iloin State	st Arund		6/	1/2012	Odento	n MD		
Baltimo permit. Page Department or Important: injury or oth		21. Signature of Funeral Service Licensee	- 10						Home, P.A.		
E P P E	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									
Physician		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.	that caused the death. I	Do not enter the	mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval 8etween Onset and		
/Medical Examiner		Immediate Cause (Final disease aHype)	rtensive At	herosc1	erotic	Cardiov	ascular :	Disease	Death		
or condition resulting in death)  Due to (or as a consequence of):											
	er	Sequentially list conditions, if any leading to immediate	r as a consequence of)	r.							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c.									
executed an and al - transit		events resulting in death) Last Due to (c	or as a consequence of)	:							
760, cate be executed physician and the burial - transit	/Medical	X UNPENDED AMEN	DED <b>23a,27,p</b>	er me,g	928 6-4-	-12 sm					
	/Me		yes, outcome of pregna	ancy				23d. Date of de	elivery		
Box 68 death certif ne attending for use as	cian	past 12 months?	Live birth Pregnant at time of dea	th =		Ectopic pregr	nancy	Month	Day Year		
Box 68 death certif the attending	Physiciar	4 Van 2 Na 0 Ulakanin	Unknown	□ Otne	r (Specify)						
, 4 7 4 l		Part II. Other significant conditions contribu	ting to death but not res	sulting in the und	derlying cause g	iven in Part I.			ute to the cause of death?		
ires the signe	d by						1 Yes	2 No 3	Probably 4 Unknown		
ords v requ shoul	Set						24a. Was a autop:		ere autopsy findings available or to completion of cause of		
He lar	Completed					· · · · · · · · · · · · · · · · · · ·	perfor 1 ✓ Yes	med? dea	ath? ✓ Yes 2 No		
al R	Be C	25. Was case referred to medical				of Death (Checl	k only one)				
of Vital Records, P.O ng Physician: The law requires that the the true certificate has been signed by meral director, page 2 should be detaclered.	To E	examiner? 1 ✓ Yes 2 No	Inpatient 2 E	R/Outpatient			ing Home 5	Residence 6	Other: Scene		
J of Jing Ph After funeral		1 W Notural	Date of Injury (Month, Day, Year)	28b. Time of Inju	·   ·	y at Work?	28d. Describe h	ow injury occurred	'		
SiOr Attend death death ctor:	catic	2 Accident Investigation				es 2 No					
Division of Vitation and Vitation of Vitation and Attending Physicious after death.  Eral Director: After this ce filled in by the funeral director.	Certification:	Suicide Could not be determined	. Place of Injury - At hor ecify)	ne, farm, street,	factory, office bu	uilding, etc.	28f. Location (S or Town, St		or Rural Route Number, City		
Iospit 4 hour uner		29a. Certifier		e death occurre	d at the time, da	te and place, an	id due to the causi	e(s) and manner a	s stated		
Division  To the Hospital ar Attendia within 24 hours after death. To the Funeral Director, / completely filled in by the fi	Medical	one) 2 Medical Examiner: On the b									
6 # <u>8</u> # 8	Me	29b. Signature and title of certifier	ine states.		29c, License	number		29d. Date signed	(Month, Day, Year)		
		(me)2			O.C.N	Л.E.		May 30, 2012	2		
		30. Name and address of person who completed		-							
			ant Medical Exam		v. Baltimore	Street, Balt	ımore, MD 21	223	<u> </u>		
St Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	beres							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 N State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George E. Wendel May 29, **20**12 6:15 A M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death County of Death Arbor Place Assisted Living Montgomery Rockville Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 X M 2 □ F Days Hours Min. 94 Country 111inois 318-12-8809 April 9, 1918 Director Usual Residence of Decedent \* show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Rockville Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be I 10g. Citizen of What Country? Funeral 20853 4413 Muncaster Mill Road United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Fo Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1943–1945 Year or Dates. 1 ☐ Yes 2 🛛 No Specify: 3 X Widowed 4 □ Divorced Specify: White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working College (1-4 or 5+) 5+ Elementary/Seconday (0-12) should be filed with and Mental Hygien is marked other the Physician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ of Health and Ments of Health and Ments of item 27 is marked or other traumatic e George John Wendel Ethel Frieda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. Robert Wendel/Son 704 Lenox Avenue, Westfield, New Jersey 07090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State June St. Mary Cemetery Lake Forest, Illinois  $\tilde{2}\tilde{0}1\tilde{2}$ 4 ☐ Donation 5 ☐ Other (Specify) . Signatur 15 heral S Rethesda-Chevy 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ kobert A. Pumphrey Funeral Home/ Chase Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Exami and-tran Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 phys the b attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia, consistent with Alzheimer's Type Completed 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive Pulmonary Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page perform death? Yes 2 K No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 IDOA this 4 Nursing Home 5 Residence 6 Nother (Spec hours after death.

neral Director; After this
if filled in by the funeral di 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🛛 Natural 5 Pending injury Accident M 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D34740 May 29, 2012 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

JUN 0 1 2012

32. Registrar's

Robert P. Fields, M.D. 18109 Prince Philip Drive #200, Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month HENRY E. WISOWATY 4:50P. Medical 29 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE TOWSON Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days Hours Min 213-14- 5920 90 1 M 2 D F **Director** 10-30-1921 MARYLAND 28a-f show 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD. BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5529 TODD AVENUE 21206 r than "natural", or items the Medical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) BALTIMORE CITY Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) TEACHER SCHOOLS event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I tem 27 is marked o မ Page 1 and 2 should be JOHN C. WISOWATY ALEXANDRA DOBRZYCKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS WISOWATY SPOUSE 5529 TODD AVENUE BALTO. MD. 21206 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY 5-31-2012 GLEN BURNIE, MD. Si tur la/Ferrice Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC, 9705 BELAIR ROAD NOTTINGHAM. Part 1. Enter the disease, or complication hock, or heart failure. List only one cal sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tions that cal Approximate Interval Between Onset and Death e on each line Immediate Cause (Final Physician/ disease or condition resulting in death) MOKE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 as the l ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: ပ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPICE To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this α completely filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔁 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1137 PM ELMER YINGLING 2012 28 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITa osedal 3cltimore Social Security Numbe 7. Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year) 9-29-1925 **Director** 220-18-2440 1 XM 2 □ F MARYLAND 86 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTO. MIDDLE RIVER 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must 6533 BLACKHEAD ROAD 21220 USA death "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceue... \_ Armed Forces? 1 X Yes 2 No. 1943-1946 Examiner 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify. 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. JOURNEYMAN MACHINIST Elementary/Secondary (0-12) College (1-4 or 5+) event, the KOPPERS COMPANY 12TH Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev VERNON YINGLING MILDRED DULL Vingling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAT SULLIVAN DTR. 6536 BLACKHEAD ROAD MIDDLE RIVER, MD. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 6-2-2012 4 Donation 5 Other (Specify) GLEN BURNIE, MD. any in Signature of Funeral Ser 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Part L. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Ph\_sician/ thmia Fatal disease or condition Arch, hours Medical resulting in death) Due to (or as a consequence of Examiner Stag Disease Renal 2 Years Sequentially list conditions, if any additions cause. Enter Underlying Cause (Disease or injury Physician/Medical Examine the Hospital or Attending Physician: The law requires that the death certificate be executed cardiovascular Disease Atherosclerotic 10 Years and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Yes by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death 2 Accident
3 Suicide Investigation M 1 Yes 2 No filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0061662 वेवाव 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan FRANKLIN SQUARE Hansen 21237 9000 DR md 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar factor DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Louis Zoberman 2012 8:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 XM 2 □ F Hours 1-15-1909 Country) Director 074-26-1444 103 Poland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits VA Fairfax 1 Yes 2 No Herndon 10e. Street and Number F 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 2619 John Milton Drive United States 20171 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 TNo If Yes, Give Year or Dates 1 Tes 2 XNo Specify. 3X Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Business Mens Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Yehuda Zoberman (Unknown) Gite1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ita Mandel - Daughter 2619 John Milton Dr., Herndon, Virginia 20171 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth David 6-12012 New York 21. Signature of Funeral Service Licensee Edward Sage 1 Danzansky-Goldberg 22. Name and Address of Facility 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ementia) disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a g Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of has page 2 performed? Yes 2 No certificate death? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work Accident Suicide after death Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical within 24 hor To the Fune completed fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier mina 5/30/2012 D0064871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fazli, Rd Rockville MD 20852 6121

State Registrar Mina

31. Date filed (Month, Day, Year,

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Montrose

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1.75 **Physician** MILTON M ZLATIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 MM 2 □ F 218-03-8575 90 07/20/1921 Director MD Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 21 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 OLD FOREST ROAD 21208 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: WHITE Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CERTIFIED PUBLIC ACCOUNTANT FINANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental LOUIS ZLATIN IDA GORELICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i SALLY ZLATIN/WIFE 3404 OLD FOREST ROAD, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) MARYLAND VETERANS 06/01/2012 OWINGS MILLS, MD 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 21. Signature of Euneral Service Licensee 8900 REISTERSTOWN KORAD, PIKESVILLE, MD 21208 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fatture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONIS Physician /Medical Due to (or as a consequence of): Examiner MIS Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a conse wence of Examiner The law requires that the death certificate be executed and bunal-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical SBS attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No 9☐Unknowr 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, should be 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 | Inpatient Other: P 2 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore homas MD 2 1215 31. Date filed (Month, Day, Year) State Registrar JUN 0 1

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Physician/ Month Robert Vaughn May 11:00 ам Autry Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring 3600 Gleneagles Drive, 7-2A Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. Director 045-16-6022 1 XXM 2 ☐ F 87 July 26, 1924 Rhode Island Jid be filed within 72 nous array.

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marked other than "natural", or items 23a or 28a-f show artic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3600 Gleneagles Drive, #7-2A 20906 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give WINTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 A No Specify. Specify: Completed 3X Widowed 4 Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Merchandise Advertisement Mgr Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be file of Health end Mental F item 27 is marked o Versey N. Autry Mary McCaffrey 20906 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Arthur Perretta/Executor 3600 Gleneagles Drive, #7-2C, Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 18. permit. Page 1 Department of I Importent: if its any injury or of 1 Burial 2 Cremation 3 Removal from State Parklawn Memorial Park Rockville, MD 2012 4 ☐ Donation 5 ☑ Other (Specify)entombment 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. In Kle C Muty 500 University Blvd. W., Silver MD 23a. Part 1. Ewer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a Respiratory Failure Medical Due to (or as a consequence of) Examiner Chronic Pulmonary Fibrosis more than 4 Sequentially list conditions. If any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of yrs To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerai Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use es the burial-transit Pulmonary Hypertension that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Coronary Artery Disease, Congestive Heart Failure 1 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X N æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 잍 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Definition Provided Figure 1 of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated Certificing Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

20+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mohsin Ijaz, MD 11119 Rockville Pike, #100, Rockville, MD 20852

May 15, 2012

6.14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra MEND#19aperFH, 5/16/12; BW, MCCo Certificate of Death 2. Date of Death 3. Time of Death 2012 Physician/ Patricia Ann Alexander May 1840 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gilchrist Hospice Social Security Number . Age (In yrs. last birthday) f Under 1 Year \_\_If Under 8. Date of Birth 9. Birthplace (State or Foreign Country) West **Funeral** Hours (Month, Day, Year) **Director** 234-74-9042 1 □ M 2 🗶 F 66 Yrs 4,1946 Virginia Usual Residence of Decedent April shov 10a. State with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No MDHoward Columbia 10e. Street and Number 10g. Citizen of What Country? Funeral 21044 7136 Winter Rose Path USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status ral", or iter Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Black Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Arbitrator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Robert Alexander Cherokee Billiups 19a. Informant's Name/Relationship (Type, Print)
Jack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton French/Husband 11716 Stonegate Lane, Columbia, MD 21044 <del>John</del> 20b. Place of Disposition (Name of Howard Universimedical School 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 5/7/12 Washington, DC Signature Juneral Service Lice 22. Name and Address of Facility Austin Royster Funeral Home Molis U.s 3821 14th Street, NW, Wash, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. PANCREATIC disease or condition resulting in death) NOVEMBER 2011 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial transit death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? certificate 2 🗌 No Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{X} \) Other (Specify) ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Injury at 28d. Describe how injury occurred 1 🗶 Natural injury 5 Pending work?
1 Yes Accident
Suicide Investigation 6 Could not be The pletely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practitioner: To the best of my knowledge, deeth 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 D64395 MAY 8, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEBAR LANE COLUMBIA, MB 21044 DANIEUE DOBERMAN, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

MAY 16 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	(	Certificate of D	eath	Reg	2012	17367		
	Physicia Medic		1. Decedent's Name (First, Middle, Last) James	Walter	Barnes,	Sr.	2. Date of Death Month May 14,	Day Year 2012	3. Time of Death		
	Examin		4a. Facility Name (if not institution, give so 12500 Kisamore La		4b. City, Town, or Flints			4c. County of Death Allegany			
	Funeral Director		210-24-0020	7. Age (In yrs. last birthd M M 2 $\square$ F 82 Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo 12/02/19	9. Birth Cou 29 Mary	nplace (State or Foreign ntry) 'land		
	ryland -f show ied at	ctor	Usual Residence of Decedent  10a. State  10b. County  MD  Alle	10c. City, Town o	r Location Flintstone	9			10d. Inside City Limits 1 ☐ Yes 2 🏋 No		
	th the Ma 3a or 28a t be notif	<b>Funeral Director</b>	10e. Street and Number 12500 Kisamore		10f. Zip Code 2153		10	g. Citizen of What Cou USA			
<b>'</b> 0	r death w	y Fune	1		13. Was Decedent of His If Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
-0036	ours afte atural", c al Exam	eted b	3 ★ Widowed 4 □ Divorced  15, Decedent's Edu	If Yes, Give Year or Dates.	1 🗆 Yes 2 ឺ No				hite		
1215	thin 72 he ene. <b>than "na</b> <b>he Medic</b>	Completed by	(Specify only highest grad	de completed) (C	ecedent's Usual Occupa Give kind of work done du fe. DO NOT use retired) Mail Carri	uring most of work	ing	6b. Kind of Business I U.S. Posta			
and 2	be filed wi antal Hygik ked other c event, t	To Be (	17. Father's Name (First, Middle, Last) Nelson	Barnes			e (First, Middle, Ma.	iden Surname)	rad		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  Beginneratt: If the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship ( <i>Typ</i> Patricia A. Kisamo	ne, <i>Print)</i> ore / Daughter 12	Mailing Address (Street an 2500 Kisamor	nd Number or Rura e Lane,	al Route Number, Co NE, Flin	ity or Town, State, Zip tstone, MD	<sup>Code)</sup> 21530		
more,			20a. Method of Disposition  1  Burial 2 X Cremation 3  F 4  One ponation 5  Other (Specify)	Removal from State cemetery,	Disposition (Name of crematory or other place and Cremato	e) !	- 1	Dc. Location - City or T			
Balti	permit. F Departm Importa any inju		21. S. nutur, of Funeral Service Licenses		22. Name and Address	s of Facility Ada	ms Famil	y Funeral			
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.					Approximate Interval Between Onset and Death		
	Physician/ Medical Examiner		disease or condition resulting in death)	a. Self Inflicted g  Due to (or as a consequence of):		nd to hea	ad		Onset and Death		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a consequence or).							
	tificate be executed ng physician and as the burial-transit	al Examiner	Cause (Disease or ilinjury that initiated events resulting in death) Last	Due to (or as a consequence of):	:						
8760	tificate be ng physic as the bu	Medical	IF FEMALE:	. <u> </u>							
. Box 68	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death to the within 24 hours after death this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use	Physician/	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No   9   Unknown	3c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death  4 ☐ Pregnant at time of death  9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of deli	very Day Year		
s, P.O	res that the signed by the details	by	Part II. Other significant conditions con	itributing to death but not resulting in t	the underlying cause give	en in Part I.		cco use contribute to	the cause of death?		
ecord	e faw requ has been ge 2 shoul	Completed					24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of		
a B	ian: The artificate ctor, pae	Be Co	25. Was case referred to medical examiner?		26. Pla	ce of Death (Check	1 🗆 Yes 2	X No 1 ☐ Yes	2 🗌 No		
$\leq$	Physic this ce al dire	ျှ	1 X Yes 2 □ No	lospital:		4 ☐ Nursing Ho		ce 6 Other (Specif	ý)		
0	ding F th. After funer	cate	27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year) 28b. Tim inju	iry work?		28d. Describe how		16		
Division of Vital Records, P.O.	il or Atten s after deal I Director: d in by the	Certificate:	2 ☐ Accident Investigation 3 ☑ Suicide 6 ☐ Could not be 4 ☐ Homlcide determined	28e. Place of Injury - At home, farm building, etc. (Specify) at home				ent shot himself Street and Number or Ryral Route Number, wn, State) 12500 Kisamore Lane stone, MD			
_	ne Hospita in 24 hours ne Funeral pleted fille	Medical	(Check 2 Medical Examine	cian: To the best of thy knowledge, de er: On the basis of examination and/or in Practioner: To the best of my knowled	nvestigation, in my opinior	date and place, an	d due to the causer the time, date and p	(s) and manner as stat	ed. ause(s) and manner stated.		
			29b. Signature and title of certifier	1/	29c. License D09 1			n. Date signed (Month, May 14, 20			
5	TRS		30. Name and address of person who con Paul Snow, M.	mple ed cause of death (Item 23a) (Typ. D., 124 West Thi	rd Street,	Cumberla	nd, Mary	Land 2150	2		
H	Stat	e	31. Date filed (Month, Day, Year)  MAY 1 5 2012	62. Registrar's Signature	arted						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 7 ່ 12 1615 Dorothy
Name (if not institution, give street and number) Buske Medical 4a. Facility **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany <u>Cumberland</u> Health Nur. & Rehab. Ctr Allegany Co. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) WV Dec 25 1 🗆 M 2 🗆 E Months Days Hours Min Director 91 Usual 23a or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Batt: If item 27 is marked other than "natural", or items 23a or 28a-f sho up or other traumatic event, the Medical Examiner must be notified at, 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 <u>730 Furnace Street</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2 2 **X**Vo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 □Widowed 4 □ Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mineral Co. Board of Ed teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Zulemma High John Beckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21502 13807 Bluebird Lane NE Cumberland George Ratke nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or 5/11/2012 MD Sunset Memorial Park Cumberland 22, Name and Address of Facility
Scarpelli Funeral Home, PA 21. Sign ture of uneral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ARTERIOSCI Physician/ disease or condition R Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury Exami burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 8 ess of person who completed cause of death (Item 23a) (Type, Print) 200 Glenn St. Ste. 302 Cumberland, MD 21505 era Jr. MD. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ BOOR Month SANDRA JEAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CUMBERLAND ALLEGANY REGIONAL MEDICAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 68 **Director** 1 🗆 M 2 🕱 F 5-13-1943 MD Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10c. City. Town or Location notified at Director MD ALLEGANY CORRIGANVILLE 1 Yes 2 No 10e Street and Number , or items 23a or iminer must be n ö 10g. Citizen of What Country? Funeral 21524 CONCORD DR. POBOX USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 M No Black, White, etc. 1 Never Married 2 Married ò 3altimore, Maryland 21215-0036 72 hours after "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) BARTENDER MESTAURANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BURKETT မ BELLE MCKENZIE WILLIAM LECLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau DEH SLABTOWN RD MT SAVAGE MD 21545 CHRISTINA J. PRATI 11711 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) RESTLAWN 5-10-12 LaVale MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility HARVEY H. ZEIGLER 21. Signature of Funeral Service Licen 169 CLARENCE ST HYNDMAN PA 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ NSTEM disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** antern Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a prequence or) Cause (Disease or injury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): attending physician for use as the buris Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day signed by tl d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires tract 1 Yes 2 No 3 Probably 4 Unknown to winary Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed' Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA မ this funeral 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After tholetely filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 5 5/8/12 D7 2514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willowbrook RD. Cumberland MD 21502 12502 Kelly iu th, Day, Year)
Y 11 2012 31. Date filed (Mo 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 06, 2012 Year John Leroy Beeman 11:35 M Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9 Jackson Street. Apt.3 Lonaconing Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Days Hours Gountry Maryland (Month Day Year) September 28, 1945 214-46-3514 Director 66 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Lonaconing 1 X Yes 2 ☐ No Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Jackson Street. Apt.3 21539 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Specify White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Laborer 6 Be 17, Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Beeman Helen Nicol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Nancy Mills - Daughter 909 Viburnum Road, #304, Odenton, Maryland, 21113 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dalelav 09 cemetery, crematory or other place Laurel Hill Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moscow Mills, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Eichhorn-McKenzie Funeral Home P.A. 22. Name and Address of Facility 8 East Main Street Lonaconing, MD 21539 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year signed by the at a be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 25. Was case referred to predical examiner? Be Division of Vital the funeral director, 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practiones. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed caus Ó 32. Registrar's Signature State 2012 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 6, 2012 11:57 AM Baumgardner Medical Theodore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Devlin Manor Nursing Home 9. Birthplace (State or Foreign Country) VA If Under 1 Year If Under 24 Hrs. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Hours Min. Month, Day, Director 218-52-8501 62 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Flintstone MD Allegany 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21530 USA 13201 Green Ridge Road filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White, etc. þ 1 Dever Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify. If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify. Completed white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pimlico Race Track Groomer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be filed nt of Health and Mental Hi E: If item 27 is marked otl 2 Helen Middleton John F. Baumgardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21234 Nancy Baumgardner ex-wife 1312 Pontiac Avenue Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a, Method of Disposition 20c. Location - City or Town, State Page 1 s Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Xemation 3 ☐ Removal from State 5/7/2012 MD Cresaptown ation 5 Other (Specify) Funeral Service Ligenses Simature 22. Name and Address of Eacility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter onderlying Cause (Disease or iinjury Due to (or as a consequence of). the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Yea Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death signed by the at d be detached for 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law I
 24 hours after death.
 Funeral Director: After this certificate has b page 2 s autopsy performe funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1-Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geatin occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29c. License number 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) DO017565 2012 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LiVele, no 12 N2+ Bullino

State

Registrar

31. Date filed (Month)

Year.

arke

82. Registrar's Signature

or Vital Records, P.O. To the Hospital or Attending Physician: Division within 24 hours after death

To the Funeral Director.

Completely filled in by the

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

6-15 Belovest Rd HEWIS W. MARR 3HALL MA 31. Date filed (Month, Day, Year) Registrar's Signature

Morarchall

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

2007660

29d. Date signed (Month, Day, Year)

5-1-2012

HYaTTSVILLE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of M State of M Registrar	aryland / Depa Cen	artment of H tificate of D			jiene <sub>Reg. No.</sub> 2	012	17373
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th 1 <sup>D</sup> ay	. Xear	3. Time of Death
	Medic	al	Doris Virginia Buckle  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Lauretina of Donath	May		2012	5:45 A M
أسميده	Examin	er	Chester River Manor		Cheste				ent	
	Funeral		1 7 11 0 77 5	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthp Count	lace (State or Foreign
	Director		215-36-0714	73 Yrs.	WIGHTIS Days	TIOUIS WIIII.	Jan 12	1939	Oodin	Maryland
	and show	o.	10a. State 10b. County	10c. City, Town or Loc	cation				10	0d. Inside City Limits
	Maryk 28a-f	Director	Maryland Caroline	Ridgely						1 🗌 Yes 2 💢 No
	h the	al D	10e. Street and Number		10f. Zip Code	1660		10g. Citizen o		try?
	ath wit	Funeral	PO Box 949  11. Marital Status 12. Was Decedent	Ever in U.S. 13 V		21660	ecify Yes or No-	U.S.	ace - America	en Indian
9	or ite	by F	Armed Forces2  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑	No	Vas Decedent of His f Yes, specify Cubar		Rican, etc.)	ВІ	ack, White, e	
003	urs af tural", al Exa		3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.					Speci		White
15-	72 ho n "na Aedic	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa kind of work done de O NOT use retired)		ing	16b. Kind of	Business Inc	lustry
212	within giene. er tha		Elementary/Seconday (0-12) College (1-4 or 8		worker		-	manı	ıfactu	ring
Maryland 21215-0036	tal Hyg	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam		Maiden Surnai	me)	
<u> </u>	uld be d Men marke natic	_	Noah Blunt  19a. Informant's Name/Relationship (Type, Print)			Beulah H		O'1 T	Ctata Zia C	
Ma	d 2 should be file alth and Mental I 27 is marked o r traumatic eve		Reuben Buckle III/son		ng Address (Street a Price St					1
Jre,	1 and of Hez		20a. Method of Disposition	20b. Place of Dispos			Cate	20c. Location		
<u>E</u>	Page ment tant: It		1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Chesapeake	e Cremati	on May 1				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatury of Funeral Service Licensee	, F1	Name and Addres	s of Facility PO I Helfenb	Box 160 ein Fun	Green	nsboro ome, P.	, MD 21639 Å
	h, i ian/		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	the death. Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Medical Examiner		10 to 1 to 1 to 1 to 1 to 1 to 1 to 1 to	a consequence of):	OK.		25.5	97		weeks
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	nsit	Examiner	cause. Enter Underlying Cause (Disease or linjury	a consequence or,						
	be executed sician and burial-transi		that initiated events resulting in death) Last C. Due to (or as	a consequence of):						
90	eath certificate be executed attending physician and for use as the burial-transit	dical	d					<u> </u>		
P.O. Box 6876	ertifica ding pl se as t	Physician/Med	IF FEMALE: 23c. If yes, outcome	of pregnancy				00.11	D-1: - 6 -1-15	
XO	attendation	ician	in the past 12 months?  1 Live Birth 4 Pregnant	2 Fetal death 3	Ctopic pregnancy Other (specify)	y			Date of delive Month	Day Year
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rds	equire een si nould	eted	Apollyrodism, He	N, 05 E19)	)					pably 4 Unknown
eco	e law r has b ge 2 sl	Completed					24a. Was a autop perfo	sy med?	prior to cor death?	mpletion of cause of
<u> </u>	sician: The law is certificate has be lirector, page 2 s	Be Co	25. Was case referred to medical		26. Pla	ace of Death (Chec.	1 Yes	2 No	1 \( \text{Yes}	2 🗆 No
Zit.	nysicia nis cer direct	일	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpat	ient 2 🗆 ER/Outpatien	nt 3 DOA Othe	r: 4 Nursing Ho	ome 5 Resid	ence 6 🗆 O	ther (Specify)	
ס ר	ling Pl	ate:	27. Manner of Death 28a. Cate of injunction 1 Natural 5 Pending (Month, Date of Injunction)	ery 28b. Time of injury	work'	? _	28d. Describe h	ow injury occu	ırred	
sior	Attenc death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inj	ury - At home, farm, stre		Yes 2 □ No	28f. Location (S	treet and Nun	ber or Rural	Route Number,
Division of Vital Records,	alor / s after al Dire		4 Homicide determined building, et		, , , , ,		City or Tow			
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or invest	tigation, in my oplnio	n, death occurred a	t the time, date a	nd place, and	due to the cau	use(s) and manner stated.
_	To the Confidence of the Confi		29b. Signature and title of certifier		29c. License			29d. Date sign		Day, Year)
	}		1/1/1/1/1, M.D.		021	5/5		5/14	1/2	
			30. Name and address of person who completed cause of c	eath (Item 23a) (Type, P	chestert	own mi	21620			
	Sta	te	XIN K. WUN 415, WW. 31. Date filed (Mogth, Day, Year) 2012 12. Registr	ar's Signature	del	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Registra	ar	MAI TO COIL ACT	4						

DHMH 17 Rev 7/2009

2 MAY 10, 2012 Baltimore, Maryland 21215-0036 ングタン 3ERDIA, certificate be Box 68760

4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min. **Director** 226-11-6647 1 X M 2 🗆 F 77 Usual Residence of Decedent shov 10b. County 10c. City, Town or Location notified at Director 28a-f Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code ō 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be by Funeral 623 A , East Main St. 20878 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) + Medical Doctor Be 17. Father's Name (First, Middle, Last) ပ္ Nandram Berdia Para 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 Asha Berdia / wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory re of Funeral Service License 23a. Part 1. Frier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final arrest Physician/ asystolic disease or condition Medical resulting in death) **Examiner** severe promobia aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last carunoma esophage or ng physician and as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 호 Division of Vital Records, Completed 24a. Was an has autopsy perform I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 X No ဂ္ဂ 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 24 hours after death. Funeral Director: After (Month, Day, Year) **X**Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier within 2 only one) 29b. Signature and title of certifier D64502 of death (Item 23a) (Type, Print) Name and address of person who completed cause 0 Brian Carpenter, MD 9901 Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ MAY VIJAY CHAND BERDIA 10, 1549 Medical 4c. County of Death Montgomery Birthplace (State or Foreign Country) (Month, Day, Year) May 9,1939 India 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Surgeon 18. Mother's Name (First, Middle, Maiden Surname) Berdia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11211 Marwood Hill Dr./ Potomac, MD 20c. Location - City or Town, State May 13,2012 | Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/Frederick, MD 21702 Approximate Interval Between Onset and Death 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Center Drive, Rockylle, Maryland 20860

State

Registrar

31. Date filed (Month, Day,

Year)

5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 11:00 a™ Brainard Recker Burgess May 9 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Ocean City Worcester 210 Beach Comber Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. Davs Director 1 🗓 M 2 🗆 F 577-22-8264 10/14/1926 85 DC Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaniner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 210 Beach Comber Lane 21842 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces?
1 

X Yes 2 

No Black White etc. 1 Never Married 2 X Married Š 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lithographic Printer Commercial Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Brianard Burgess Lavenia Reinburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura P. Burgess / Wife 210 Beach Comber Ln., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 Donation 5 Other (Specify) 05/12/2012 Resurrection Cemetery Clinton, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ardio vercular Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No eral Director: After this certificate filled in by the funeral director, pag 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 76 who completed cause of death (Item 23a) (Type, Print) Coastel State

Registrar
DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Claire May 11 Diane Bacon 2012 0845 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9201 Fourth Street Prince Georges Lanham If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours oct II 194<u>3</u> New York **Director** 062-36-2565 68 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Yes 2 ☐ No Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò should be filed within 72 hours after death with the and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be I Funegal 201 Fourth Street 20706 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edna Phelan Theodore Jamison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Lee Bacon (Son) 5419 Smooth Meadow Way Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake Crematory 05/15/2012 Beltsville, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or iinjury that initiated events resulting in death) Last Due to-for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Year signed by: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 🗌 No Yes 25. Was case referred to medical director, æ 26. Place of Death (Check only one) examiner? 2 🗌 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5  $\square$  Pending work? 1 \( \text{Yes} within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

VALOR

31. Date filed (Month, Day, Year)

20

001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 24, <sup>2</sup>2012 Lee Carder 11:00 PM Medical Alvin 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett Goodwill Mennonite Nursing Home Grantsville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Hours Mar 17 Director 217-18-4028 1923 89 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Garrett Grantsville 1 XYes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 891 Dorsey Hotel Road 21536 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 XVidowed 4 Divorced WWII white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chessie Systems <u>machinist</u> and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Powelson Marshall G. Carder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip WV 26753 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Marshall L. Carder son Rt. 2 Box 590 Ridgeley 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Amenation 3 Removal from State 5/25/2012 4 Donation 5 Other (Specify) Scarpelli Funeral Home, P.A. Cresaptown MD 22. Name and Address of Facility Scarpelli Funeral Home, PA of Funeral Serv 108 Virginia Avenue: Cumberland, MD 21502 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card ac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month . . par the 9 Unknown be detacl signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural Accide 5 Pending I hours after death. 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier eem

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Wary State Regist AMEND#1perMD, 5/29/12; BWW, MoCo Certificate of Death 2. Date of Death Marquez AKA Luis Cedillo Physician/ -Luis Cedillo 05/14/2012 10:18 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Director None 1 M 2 - F 56 09/01/1955 Honduras ms 23a or 28a-f show must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits Md 1 🔀 Yes 2 🗌 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1001 Rockville Pike 20852 Honduras or items 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces 1 X Never Married 2 - Married Black, White, etc. à 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Hondurian "natural" 3 Widowed 4 Divorced Completed Specify: Hispanic Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 9th Labor Cleaning Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Maria Concepcion Marquez Unknown and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 s ment of Health a 27 Mardoel Marquez/Brother 1001 Rockville Pike, Rockville, Md 20852 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) General Cemetery 05/21/12 Honduras 22. Name and Address of Facility John T. Rhines Funeral Home 21. Signature of Funeral Service Licensee Bill Phillip 3005 12th. St. NE Washington D.C. 20017 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage Kidney Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enfor Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy that the death in the past 12 months? 5 Other (specify) Pregnant at time of death Month Dav Year 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 No of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🔀 No ၉ 1 X Inpatient 2 - ER/Outpatient 3 - DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury Division work? Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 22 To the F only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D 67986 05/14/12 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Yueng Li 8600 Old Georgetown Rd. Bethesda, Md. 20814 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

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10:18

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:00 A 2015 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairfield Nursing& Rehab Center Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 579-14-5936 Director 1 □ M 2 🗓 F 90 1/9/1922 Washington, DC shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ler must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Maryland | 1 Yes 2 X No Anne Arundel Annapolis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 800 Bestgate Road #229 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced White Year or Dates t of Health and Mental Hygiene.
If item 27 is marked other than "natur
or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mabel Ε. Harding Clarence Bea11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlie Barnes/Son 3002 Bass Place, Riva, MD 21140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 9 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Parklawn Mem'1 Park | 5/18/2012 4 □ Donayion 5 🛛 Other (Specify) En/combment Rockville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 alas 23a. Part 1. Enter the disease, or comp ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final esepsonascular Ph\_sician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Destension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for an a consequence on ig physician and as the burial-transit Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ been signed by the atter should be detached for i Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been six completely filled in by the funeral director, page 2 should I Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractitioner To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0070693 47 05-14-2012

Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hazel Mae Copsey 2012 5:30 A May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown Social Security Number If Under 1 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 10/25/1936 Mary Land 75 Director 220-34-3880 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 🏿 No Mechanicsville St. Mary's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō items 23a Funeral 20659 USA 40395 Delabrooke Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 X Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 11 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Monta Important: If item 27 is marked any injury or other. ပ Mary E. Hayden John Louis Tippett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40395 Delabrooke Road Mechanicsville, MD 20659 Franklin B. Copsey/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/26/2012 Queen of Peace Helen, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral 41590 Fenwick Street Leonardtown, MD Home, P.A. 20560 X 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 15chung Strake Immediate Cause (Final Large Phylician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner nemona Ara TIGH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Copsex, 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours affer deaun.

To the Funeral Director: After this commisted filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 2 Accident 5  $\square$  Pending Investigation 3 Suiciue 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 7/2009

State

Registrar

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MAY 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Mehrdad Akhlaghi, MD, St Mary's Hospital, 25500 Pt Lookout Rd, Leonardtown MD 20650

DO60473

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death May 11, Physician/ 9:00 P. M 2012 Abel Clinton Clement Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Mt. Airy 3804 Mount Airy Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours $March^{(Month, Day 2^{\text{year}})} 1926$ New Jersey 153-28-7855 86 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits at 10a. State 10c. City. Town or Location Director items 23a or 28a-f s ner must be notified Mt. Airy Maryland Carroll 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21771 3804 Mount Airy Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc ò 2 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 ner than "natural", c ), the Medical Exam 1 ☐ Yes 2 K No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Commerical Elementary/Seconday (0-12) College (1-4 or 5+) Estimator Construction traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Harriet Yarder Keiser Abel Clement 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 21771 3804 Mount Airy Drive, Mt. Airy, Maryland Carol J. Clement - wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5-14-2012 Frederick, Maryland Stauffer Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ormary duears disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the burial-transit and that initiated events Due to (or as a consequence resulting in death) Last physician Physician/Medical P.O. Box 68760 signed by the attending p IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown Month Dav Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has performed? Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: I or Attending F after death. 5 Pending work 1 Yes 2 No 2 Accident 3 Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar DHMH 17 Rev 7/2009

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State

and address of person who

ENKUMIN

1.

+apoi

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ARLAM.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

H58132

9815 Main St, Ste Z48, Damasous MD Z4872

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 O'Connor May 6, 8:45 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton 1670 Albermarle Drive Anne Arundel Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Months 91 Director 579-14-1888 1 □ M 2 Ϊ Jan 12, 1921 Washington, DC Usual Residence of Decedent 28a-f show 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Anne Arundel Crofton 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21114 1670 Albermarle Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14 Race - American Indian Armed Forces . or Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 within 72 hours after Yes 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White "natural", 3 ☐ Widowed 4 ☐ Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) 12 and Mental Hygiene. Own Home Homemaker is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William O'Connor Ruth Rabbit and 2 should b Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1670 Albermarle Dr. Crofton, MD 21114 William Martin Clark - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of I Important: If it any injury or of once. o To 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 5 Other (Specify) Stauffer Crematory Inc. 5/11/2012 Frederick, Maryland 4 Donation 21. Signature of Funeral Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complicat shock, or heart failure. List only one of such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires twithin 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, name? should ha Records, 1 Yes 2 1 You 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes د 🗅 2 Other: ျ 1 Inpatient 2 ER/Outpatient 3 I ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specific 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

Registrar

State

30. Name and address of perso

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31. Date filed (Month

Lichtenstein, M.D. 205 Ridgely Avenue, Annapolis , Maryland 21401

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 23:50P M Sharon Yvette Chase 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year \_ If Under 24 Hrs. . Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 213 56 5972 Director 59 1 M 2 X F 12/18/1952 MD 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's District Heights 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1922 County Road #T3 20747 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married b 2 X No Yes Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien is marked other th 12 Supervisor Nursing Facility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Harry P. Fenwick Edna Dent other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Tonya L.Chase/Daughter 3119 Ayres Ct. Waldorf, MD 20603 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Sacred Heart Cem. 5/23/2012 4 ☐ Donation 5 ☐ Other (Specify) Bushwood, MD 22. Name and Address of Facilit Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses Kembruy ( 38576 Brett Way Mechanicsville, MD 20659 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner for as a consequence on and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical certificate be Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No The law requires that the death ģ Month Pregnant at time of death Day Year by the been signed by the a should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy is certificate h I director, page performed 2 No Yes 2 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 inin 24 hours after deam.

the Funeral Director: After this of the funeral director is the funeral director. ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury Natural 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier ٥

Registrar

DHMH 17 Rev 06-2011

death (Item 23a) (Type, Print)

mpleted caye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Menth May Frances 10 Ann Custis 2012 8:50 a. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Center Dorchester Cambridge 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Jan. 23, 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign Months Hours **Director** 220-66-3825 Yrs Mississippi 57 1955 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3416 Indian Bone Road 21613 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō ð 1 Never Married 2 Married 1 Yes 2 X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: white "natural" 3 Widowed 4 X Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) nursing home registered nurse marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Robert A. Cire Audrey Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Levi Custis 27 son 3318 Woodland Acres Rd., East New Market, MD 21631 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 🔲 Burial 2 😾 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 5/11/12 Delmar, DE 21. Signature of Funeral Service Licer 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ Pheumonia disease or condition 1045 Medical resulting in death) Jue to (or as a consequence of) **Examiner** cerebellar degeneration Sequentially list conditions, if any country course cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence on burial-transi Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending p ass IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? certificate 1 Yes 2 No al or Attending Physician: The safter death.
I Director: After this certificat Yes 2 No Division of Vital To Be filled in by the funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral D Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ompleted

State Registrar (Check

only one

29b. Signature and title of certifie

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100 Brankle

ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

	For State Registrar			J1 1V1	ar yrarra	•	tificat			una n	/lental H	Reg. I		12	173	385	
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ner	50 Appea	1 Lane,	Apt. #10	05			Lu	sby	Location of				c. County				
	5. Social Security N 558–48–4		6. Sex 1 🌠 M 2 🗆 F		e (In yrs. last i <b>74</b>	birthday) Yrs.	If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, 08/04		7	9. Birthp Coun	olace (State or try) OK	Foreign	
ا ا	Usual Residence of Decedent  10a. State 10b. County				10c. City, To	own or Loc	ation							14	0d. Inside City	u Limita	
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To Be	17. Father's Name (		ast)		I				18. Mothe Ruby			le, Maide	Maiden Surname)				
		ise Co	nip (Type, Print) oper – Dat	ugh							n Route Num re, Ca						
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	21. Signature of Fu	neral Service L	icersee	C					s of Facility $\times$ 600		ausch usby,						
dical Examiner	shock, or heal Immediate Cause (disease or condition resulting in death)  Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated event resulting in death) in the condition of the cause (Disease or that initiated event resulting in death) in the cause (Disease or that initiated event resulting in death) in the cause (Disease or the cause (Disease or the cause of the	onditions, mediate rlying iinjury s	a. Due to b. Due to c.	(or as	f.	ce of):					. (opiaci)				Approximate Interval Betw Onset and Di	eath	
Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth Inant a	of pregnancy 2 ☐ Fetal de t time of deat	eath 3 🗌	Ectopic p Other (sp		у				23d. Dai Mo	te of delive		ear	
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To Be	25. Was case referre examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{S} \)	No medical	Hospital:	Innetia	ent 2 ER	(Outpation	3 🗆 🗆	Otho	ace of Deat			-1-1	a 🗆 ou	<i>6</i>			
Certificate: T	27. Manner of Death  1 Natural 2 Accident	h 5 Pendin Investig	g 28a. Date (Mon	of inju		b. Time of injury		8c. Injury work	at		me 5 Re 28d. Describ						
	3 Suicide 4 Homicide	6 ∐ Could i determ	ined 28e. Place		ury - At home c. (Specify)	, farm, stre	et, factory	r, office				(Street a own, Sta		er or Rural	Route Numbe	er,	
Medical	(Check 2 only one) 3	!	Physician: To the b xaminer: On the bas Nurse Practioner:	sis of e To the	xamination an best of my kn	ıd/or investi	gation, in reath occur	ny opinio red at the	n, death oc time, date	curred at	the time, dat	e and place	ce, and due	to the cau	ise(s) and mani	ner stated	
	29b. Signature and	title of certifier	Felul	1	mo			. License 341					ate signed y 14				
	30. Name and addre																

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 Counts May 12 1:05 Margaret A M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours Director 577-40-2288 1 □ M 2 🛣 F 89 09-16-1922 England show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 X No <u> Anne Arundel</u> Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5550 Franklin Boulevard 20733 England Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Drug Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CoxFrank ONei11 Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip R. Counts, Son 9023 Michael Way, Owings, MD20736 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 05-14-2012 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. MO0715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death

5 MONHS Physician. cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 🗌 No the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practitioner: To the best of my monthing to other at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time. 29a. Certifier (Check only on 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) JRW) Medical Parkway, Annapolis, Md. MI 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ethe 11:50 2012 ARI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Prince 9. Birthplace State or Foreign Country) tosp.ta If Unde 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min 52-9908 **Director** 1 🗆 M 2 🕱 F 1934 Usual Residence of Decedent 28a-f show 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland 7 10e. Street and Number 1 Yes 2 No 10g. Citizen of What Country? Funeral 10402 20772 Was Decede It Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 3 No and Mental Hygiene. is marked other than "natural", 1 Yes 2 No Specify 3 X Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Wills 19a. Informant Name/Relationshi ype, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Robinson Important: If item 27 of Health MI Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Mcensee 22. Name and Address of Facility 3000 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 88 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ be detached for in the past 12 months? Month Dav Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician; The law autopsy certificate has 2 🗌 No Yes 2 No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifier completely (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29c. License number

State Registrar 8/18 Good Luck Roma

(Item 23a) Type, Prin

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene	
		_	Registrar Certificate of Death Reg. No. 2012 138	ğ
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	Medi Examir			-
The same of	<i>?</i>		Prince Georges Hospital Cheverly Prince Georges	
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min (Month Day Year)	jn
i,	Director		244-70-7807 1 □ M 2 □ F 67 Yrs. Mar. 12, 1945 NC	
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	Maryl 28a-f otifie	Director	MD Prince Georges Capitol Heights 1 ☐ Yes 2 🖾 N	10
	h the	<u>a</u>	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	$\neg$
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21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2 X No	
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	1 and 2 and Health item 27 other tra		Johnnie Coley, Sr Husband 918 Brooke Rd. Capitol Heights, MD 20743	
lore			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) Washington National 5-19-2012 Suitland, MD	_
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee  Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Onset and Death	- 1
	Physician Medical		Immediate Gause (Final disease or condition resulting in death)  Onset and Death  Onset and Death	4
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	- +	iner	Sequentially list conditions, b. Duarta or an endisreption of growth of the cause. Enter Underlying	$\neg$
	and trans	Examiner	Cause (Disease or injury that initiated events c. Schemic Cardiony) (2T)	
0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affact death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical E	resulting in death) Last  Due to (or as a consequence of):  END STAGE GENAC DISEASE	
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289	eath certifica attending pl	N/S	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Вох	death	Physician/Me	in the past 12 months?  1  Yes 2 No  1  Yes 2 No  Month Day Year	
P.O.	at the	Phy	Port II Other significant conditions coddition to a death but a de	$\dashv$
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ecc	e has	Completed	24a. Was an autopsy findings available autopsy performed?	
<u>=</u>	an: Th tificat tor, pa		1   Yes 2   No   1   Yes 2   No   25. Was case referred to medical   26. Place of Death (Check only one)	$\dashv$
Z <u>i</u> t	nysicii lis cer direc	To B	examiner? 1   Yes   2   No	$\neg$
of	ng Pl		27. Manner of Death 1 Manual 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28b. Time of injury work? 28d. Describe how injury occurred work?	
ion	ttendi death tor: A the f	Certificate:	2 Accident Investigation M 1 Yes 2 No	
Division of Vital Records,	l or A after Direc	Cer	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	spita hours neral y filled	ical	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	-
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	ed.
	Vith vith		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	6		D'12539 05/12/12	
	A	,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  OMOING	Q.
	Stat	е	31. Liate Ned (Moath, Day, Year) / 32. Registrar's Signature	2
	Registra	ır	3 AV 18 2012 Sener D. Janes	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 05 Physician/ 2012 8:26 PM E. Carter, Jr. Francis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Crescent Cities Center Riverdale Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, **Funeral Director** 577-52-8101 1 X M 2 D F 74 05/03/1938 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1

Yes 2 □ No Oxon Hill MD Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 20745 1809 Mystic Avenue filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black White etc þ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Variety of Duties 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဂ Helen Tolson Francis E. Carter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2303 Catskill Street, Temple Hills, MD 20748 Wanda Exum/Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/19/2012 Suitland, MD Lincoln Cemetery Signature of Funeral Service Li-22. Name and Address of Facility Marshall-March Funeral Home 4217 9th Street NW, Washington, DC 20011 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate hock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final URFTHRAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin PROSTA attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: <u>\_</u> 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 000 57518 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Branch Ave Temple HILL, MD 20748

Registrar

State

Date filed (Month, Day, Year,

MAY 18

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>D</sup>2012 Physician/ Month May Faye Allen Dixon 0512 24 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u> Gilchrist Hospice</u> Towson Baltimore County Social Security Number If Under 1 Yea Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 220-54-7203 Months Hours Min. Director 1 M 2 XF 57 Yrs. July 21, 1954 Maryland Usual Residence of Decede ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD 1 Yes 2 No Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2202 Sandymount Rd. 21048 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No artment of Health and Mental Hygiene. octant: If Item 27 Is marked other than "natural", or i injury or other traumatic event, <u>the Medical Examin</u> Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Carroll County Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clifford E. Keffer Faye V. Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 street of Health a tant: If item 27 b Jessie Dixon/Daughter 2202 Sandymount Rd. Finksburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sandy Mount Cemetery 5/27/2012 Finksburg, Maryland Sgnature of Funeral Service Licensee 22. Name and Address of FacPritts Funeral Home & Chapel, PA K 412 Washington Rd. Westminster, MD 23a. P in 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ realic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed siclan and burlal-trans Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 Dono 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No After this certificate I funeral director, pag 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending Division work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 🗘 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) MMY 27 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TOUSON MI) MM 670 31. Date filed (Month, Day, Year 32. Registra State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Anne Richards DeWolf May\_ 9:15A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing Center Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/15/1936 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 7. Age (In vrs. last birthday) 1 🗆 M 2 🛣 F Months Min 212-36-0139 76 Director Usual Residence of Decedent 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Anne Arundel Sherwood Forest 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 814 Robin Hood Hill 21405 USA ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 XWidowed 4 ☐ Divorced "natural", Completed Specify. Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Veterinary/ and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Naval Academy Administrative Assistant vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Roland Richards, III Adelaide Wederstrandt Johnson other traumatic 19a. Informant's Name/Relationship (Type, Print) Heidi G. Wood/ Daughter Department of Health ar Important: If item 27 is any injury or other traunonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 Robin Hood Hill, Sherwood Forest, MD 21405 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 5/15/12 Edgewater, MD of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner ue to (or as a consequence of): attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? or Attending Physician: The certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending To the Hospital or Attendir
within 24 hours after death.
To the Funeral Director: Af
completed filled in by the fur 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License number who completed cause of death (Item 23a) (Type, Print)

State Registrar Burne MD21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Glen Dale Dennison 2012 6:35 P M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Health Care Center of Waldor Charles Waldorf If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign Country) (MD) Capitol Heights Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Sex 1 ♣ M 2 ☐ F Days Hours 03/18/1934 78 579-42-7815 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🄀 No MD Charles White Plains 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 10280 Billingsley Road USA 20695 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 'n, by Maryland 21215-0036 within 72 hours after 1 🗌 Yes 2 🗓 No If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Construction / Elementary/Seconday (0-12) College (1-4 or 5+) 10 Painting Contractor Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Raymond Baker Dennison Daisy Lou Wamsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10280 Billingsley Rd., White Plains, MD 20695 <u> Mary Ann Dennison / Wife</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Brinsfield-Echols Crem 05/21/2012 Charlotte Hall. MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Signature #M00817 ion 30195 Three Notch Rd., Charlotte Hall, MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph.si i.n. disease or condition mellia Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a disequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be as the b IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Por Month Year 5 Other (specify) detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number completed cause of death (Item 23a) (Type, Print)

Registrar

State

id Washing

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	Maryland / Dep			Mental Hy	giene Reg. No. 2	012	17393
			Registrar  1. Decedent's Name (First, Middle	e, Last)	Certificate of Death					UIC	3. Time of Death
н	Physicia Medio		Peggy	Lenora	Dixon			2. Date of De Month <b>May</b>	22 <b>Day</b>	Year <b>2012</b>	9:44 P M
-	Examin		4a. Facility Name (if not institution			4b. City, Town, or	Location of Death			inty of Death	7.44 1
أمعودوا			Hospice Hous	se of St. Ma	ry's	Ca	11away			St. Mar	y's
	Funeral		5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birthp Count	lace (State or Foreign
	Director		577-34-4403 Usual Residence of Decedent	1 □ M 2 🛣 F	<b>83</b> Yrs.			10/12/	1928	Wash	ington, DC
	and show lat	o	10a. State 10b. County	<u> </u>	10c. City, Town or Lo	cation	l			11	0d. Inside City Limits
	Maryl 18a-f tifiec	Director	Maryland St.	. Mary's	Leo	nardtown					1 🕱 Yes 2 🗆 No
	a or 2	Ē	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?
	h with	Funeral	22680 Cedar L	ane Road			20650		U	S A	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.1	Race - America Black, White, e	
36	after al", o xam	d by	1 ☐ Never Married 2 ☐ Mar 3 👿 Widowed 4 ☐ Divorced	If Yes, Give	d No	1 ☐ Yes 2 🛣 No	Specify:		Spe		ite
21215-0036	natur ical E	Completed	15. Decede	nt's Education	16a, Dece	dent's Usual Occup	ation		16b Kind o	of Business/Inc	histo.
215	n 72 e. an "r Med	mp	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-4 or	(Give	kind of work done o O NOT use retired)		king	TOD. Talla c	Dusiness/inc	adoti y
21			12	J College (1 4 of		istant Ma	nager		Newspa	aper Ci	rculation
nd	e filed Ital Hy ed oth	To Be	17. Father's Name (First, Middle, L	ŕ			18. Mother's Nan				
Maryland	permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic ew once.	_	Edmund Roge		0.00		Joseph		ılia	Kelly	
$\mathbf{N}$	2 sho th an 27 is trau		19a. Informant's Name/Relations  Bonnie Hoepfin			ng Address (Street a					va 22408
ē,	f Heal	Ш	20a. Method of Disposition	iger/Daugnee	20b. Place of Dispo	osition (Name of		Date		on - City or To	
mo	age ent o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		e cemetery, crei	matory or other plac					,
Baltimore,	mit. F partm porta r injui		21. Source of Funeral Service		25	f Peace  2. Name and Addres	s of Facility	5/2012		n, MD	
ä	an De d		Michael	Laroline	r	Mattingle 41590 Fer	y-Gardin wick St.	er Fune Leona	ral Ho rdtown	me, P.A.	0650
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause	ed the death. Do not ent						Approximate Interval Between
~ .	Physician		Immediate Cause (Final disease or condition		njestive He	art Failu	ıre				Onset and Death
	Medical Examiner		resulting in death)		a consequence of):						İ
		<u>.</u>	Sequentially list conditions	D	ronic Renal	Failure					
		n in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	xecut n and al-trai	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):						
09	ate be executed hysician and the burial-transit	dical		C <sub>d</sub>							
6876	ficate g phy as th	Med	IE FEMALE.						- 1		
9	eath certifica attending p	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐ Ectopic pregnanc	V		23d.	Date of delive	ry
Вох	death he att	Physician/Me	in the past 12 months?  1 Yes 2 No		at time of death 5	Other (specify)				Month	Day Year
P.0.	requires that the des been signed by the s should be detached	Phy	9 Unknown  Part II. Other significant condition	ons contributing to death	but not resulting in the	Inderlying cause giv	en in Part I	OOn Did A			- course of death 2
υ, Ο,	es tha	d by	Tarin Guler Significant Condition	mo contributing to death	but not resulting in the t	anderlying cause giv	GITTI CILI.				e cause of death?
ırds	requir	Completed									
oce.	The law cate has I page 2 s	mp						24a. Was auto	osy		sy findings available npletion of cause of
<u> </u>	n: The ficate or, pa		25. Was case referred to medical	_		00.00		1 Yes	2 No	1 🗌 Yes	THE PARTY NAMED IN
/ita	Physician: T r this certifica eral director, p	To Be	examiner? 1  Yes 2 No	Hospital:	tions 2   FB/Outsetin	Othe	er:			211 12 11 1	House
of	r Attending Phy ter death. rector: After this by the funeral d		27. Manner of Death	28a. Date of inj		f 28c. Injury	/ at	ome 5 Resident			nouse
O	andin ath. r: Aft	icat	1 Natural 5   Pending   (Month, Day, Year)   injury   work?   2   Accident   Investigation   M   1   Yes 2   No								
Division of Vital Records,	or Atte	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rocity or Town, State)								Route Number,
Ö	oital o urs af ral Di	alc									
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  Of the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical E	Physician: To the best of Examiner: On the basis of	examination and/or inves	tigation, in my opinic	n, death occurred a	at the time, date a	ind place, and	due to the cau	se(s) and manner stated.
	omple	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	g Nurse Practitioner: To t r	the best of my knowledge	, death occurred at t		lace, and due to		nd manner as signed (Month, E	
	F > F 0		1	000			55751			22, 2	
	A		30. Name and address of person	who completed cause of	death (Item 23a) (Type. I					,	
21	le le		Jennifer M.	· ·	40900 Merc		ne, Leona	rdtown,	MD 20	650	
	Stat		31. Date filed (Month, Day, Year)	2012 2. Regist	rar's Signature	Ne.					
	Registra	II.	MAIAT	CUIC NOT	المراجور المراح						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended #1. per Doctor Certificate of Death AJS CCHD 5/18/12 1. Decedent's Name (First, Middle, Last) Dennis Jr. 2. Date of Death Renzie E Physician/ Month-201 Medical 258 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location or BALTIMORE City, Town, or Location of Death 4c. County of Death NURSING & REHAB POLNT MD 2121 Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary land **Funeral** 8. Date of Birth 1**X**XM 2 □ F Months Hours Min (Month, Day, Year) 219-56-7722 Director 61 12\_1950 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD QueenAnn Grasonville Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20607 Cemetery RD. U.S. 72 hours after death 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Never Married 2 Married "natural", or Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic mans. Elementary/Seconday (0-12) College (1-4 or 5+) Handyman Home Imp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Renzie Elton Dennis Sr. Goldie Mae Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Lane-Sherwood P.O. Box 12 Greensboro MD. 21639 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Spring Hill 5-23-2012 Denton MD. 21. Signature of Funeral Service Licens 22. Name and Address of Facility McPherson Funeral Service Milford DE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Squemous Cell Cas unoma Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner to thrine Failure Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No Yes & 1 Yes **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one 29b. Signature and title M.D. D72536 05-16-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -821 N Eulan St Suite 308 Balymore MD BUUTANI State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend#20b.perfuneralhome5/18/2012/ccdoh/ba
Certificate of Death
Reg, No. For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vincent George Dickens 15 20<sup>Year</sup>2 11:17AM Mav Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospice St. Mary's Callaway Social Security Number 8. Date of Birth (Month, Day, Year) 6 – 26 – 1936 **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Birthy) Country) MD Hours 1 X M 2 - F 214 36 4135 Director 75 Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10h County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director St. Mary's Lexington Park MD 1 X Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20653 USA 21464 Exquisite Court death v 12. Was Decedent Ever in U.S. Armed Forces?

12. Yes 2 □ No If Yes, Give 1 9 5 6 - 6 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. o 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ James Orville Dickens Viola Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Frederick/Sister 32369 Upland Dr. Bushwood, MD 20618 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State  $05/25^{\text{pate}}2012$ cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) St.GeorgeCath.Cem.<del>05/26/2012</del>Valley Lee, MD 21. Signati of Funeral Service Licens 22. Name and Address of Facility Briscoe-Tonic Funeral Home 38576 Brett Way Mechanicsville, MD 20659 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a c equence of) Examine Sequentially list conditions, if any leading to immediate Examiner if any leading to immedicause. Enter Underlying Due to lor as a consequence of Cause (Disease or iinjury the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 2 No 1 Yes 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X**No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury death. Investigation 6 Could not be ☐ Accident within 24 hours after deat To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month. Day, Year, 20650 who completed cause of death (Item 23a) (Type, Print) 40900 Merchants Lane M.D earcudtaus, Mo Schmidt Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ UMBERTO DISABATINO 0257 2012 Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of Mayland Medical Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 578-44-7726 **Director** 1 🛛 M 2 🗆 F 88 1/31/1924 Italy Usual Residence of Deceden 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ms 23a or 28a-f sho must be notified at Director MD Calvert 1 X Yes 2 □ No Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12740 Springfield Court 20754 USA items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò 1 Never Married 2 X Married þ Yes 2 No altimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify "natural", Completed 3 Widowed 4 Divorced White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hverimportant: If item 27 is many injury or other. Barber Shop Barber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Armanda Speca Nicola DiSabatino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Armida DiSabatino/Wife 12740 Springfield Ct., Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) Entomb Resurrection Cem 5/17/12 Clinton, MD 21. Signature of Funeral Service Larensee<sup>1</sup> 22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Physician/ Myelogenous disease or condition Medical resulting in death) Due to (or as a consequence of): 5/2011 - 5/2012 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No М ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, MD 25712 2012

State Registrar 22 S. Greene St. Greenebaum Cancer center.

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

MD

Year)

MAY

Bryon Tseng

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of M	aryland / Dep	artment of F rtificate of L			jiene Reg. No. 2 N	12	17397
	Physici	an/	1. Decedent's Name (First, Middle, L.	,	Danc	<b>FU</b>		2. Date of Dear	th	3. T	ime of Death
,	Medi Exami	cal	REBEC 4a. Facility Name (if not institution, gin		DORS		Location of Death	Mar	4c. County of		3cc PM
			Northwest Hosp		oice	Randal			,		
	Funeral Director		5. Social Security Number 6.	Sex 7. Aga 1 □ M 2 🔀 F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (S Country)	State or Foreign
			Usual Residence of Decedent	TLIM ZXF	70 Yrs.			01/19/	1942	VA	
	aryland a-f sho fied at	cto	MD Baltim		10c. City, Town or Lo						side City Limits
	the Ma or 28a e noti		MD Baltim  10e. Street and Number	ore	Baltimo	re 10f. Zip Code			10g. Citizen of W		Yes 2 X No
	h with ns 23a	nera	35021 Howard P	ark Avenu	ue_#105	2120	7		LIS	,	
36	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 If Yes, Give	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race Black	- American India , White, etc.	an,
5-0036	hours natura Jical E	lete	15. Decedent's	Year or Dates. Education		dent's Usual Occupa		- 1	16b. Kind of Bus	Black	
2121	within 72 giene. Ier than " t, the Mec	omo	(Specify only highest g	rade completed) College (1-4 or 5	life E	kind of work done d O NOT use retired)	uring most of work	king	TOD. KING OF BUS	miess/moustry	
	filed wit al Hygie d other	Be	9th 17. Father's Name (First, Middle, Last)		D	isabled	19 Mother's New	ne (First, Middle, N	Not App	olicab	le
/lan	should be filed within 7/3 and Mental Hygiene. 7 is marked other than raumatic event, the Me	유	Anthony Green				Bertha		,		
, Maryland	and 2 shoul Health and I em 27 is ma		19a Informant's Name/Relationship Kasina Dorsey/	Type, Print) Daughter	19b. Maili 109 W	ng Address (Street a. 'hite St	nd Number or Run	al Route Number	City or Town Sta	25302	
Baltimore,	e = = =		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 L 4 🗋 Donation 5 🗀 Other (Spec	Removal from State	20b. Place of Dispo cemetery, cree Mt.Ray C	natory or other place	e) i	Date 19/2012	20c. Location - C	•	ite
Balt	permit. Page Department Important: any injury o		21. Signat e Funeral Service en	Spe /	22	Name and Address	s of FacilityPoc	le's Fu	uneral	Home	77 2242
ı	4,75		23a. Fart 1. Enter the dispase, or con shock, or heart failure. List only	plications that caused one cause on each line.	the death Do not ont	er the mode of dying	, such as cardiac	or respiratory arres	st,	Approx	ximate al Between
die	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		MONT	7					and Death
-	Examiner			Due to (or as a	consequence of):						
	n #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):		· ·				
	ficate be executed g physician and as the burial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):			_			
0	e be e) ysician ie buris			d	,						
98760	rtificat ing ph e as th	/Med	IF FEMALE:				-				
. Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1  Yes 2  Oo 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date Monti		Year
P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	by Pr	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribu	ute to the cause	of death?
ďs,	equires een sig ould b	ted				1-1-		1 🗆 Yes	s 2 🗆 No 3	☐ Probably 4	4 Unknown
900	has be	Completed						24a. Was an autopsy	pric	ere autopsy findir or to completion	ngs available of cause of
= R	in: The ificate or, pag		25. Was case referred to medical					perform		ath? Yes 2 No	,
Vita	nysicia iis cert direct	To Be	examiner? 1 ☐ Yes 2 <b>I</b> No	Hospital:	nt 2 ER/Outpatien	Othor	e of Death (Check	only one) me_5 □ Resider	no 6 Dothar	705 P	20
J Of	ing Ph	ate:	27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day,	28b. Time of	28c. Injury a		28d. Describe how		<i>эреспу</i> )	
Division of Vital Records,	Attend death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e	y - At home, farm, stre	M 1 □ Y	es 2 No				
Divi	tal or / s after al Dire ed in b		4 Homicide determined	building, etc.		et, factory, office		28f. Location (Stre City or Town,		or Rural Route N	lumber,
	Hospii 24 hour Funera tely fill	Medical	Grieck Z   Medical Exam	sician: To the best of miner: On the basis of exa	amination and/or invest	dation in my opinion.	death accurred at	the time date and	place and due to	+ +h = ================================	d manner stated
	To the vithin 2 the comple		only one) 3 Certifying Nurs	se Practitioner: To the	best of my knowledge,	death occurred at the	time, date and pla	ce, and due to the	cause(s) and man	ner as stated.	
	7-		1 Star	John	_ 111	2 13/3	5877		1		-
	00/2		30. Name and address of person who o			. A	01 1	Hen	1	2	111
	Stat	e :	31. Date filed (Month, Day, Year)	3 6934 32. Registrar!	's Signature.	Tion	Blud	Men	BURN	ہے جرا	06/
	Registra	-	MAY 152	012	~ h. b	all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 17398 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ENTSUA-MENSAH MAY ISAAC 2012 2200 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Director 577-86-8123 1 🖾 M 2 🗆 F 67 Aug. 19, 1944 West Africa Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Prince Georges Capitol Heights 10e. Street and Number ō 10f. Zip Code "natural", or items 23a or 10g. Citizen of What Country? Funeral 1010 Kayak Ave. 20743 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🛣 No Yes, Give 72 hours after 1 ☐ Yes 2X No Specify: 3 Divorced Specify: Completed **Black** Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "I Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Auditor Dept of Public Works Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ebenezer Entsua-Mensah Rosina Annan 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is to any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isaac Samuel Entsua-Mensah/Son 1010 Kayak Ave. Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 5-25-2012 Alexandrai, VA Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland ictorine 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Acute Respiratory Failure Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury Pneumonia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ası nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Multiple Myeloma 24a, Was an has autopsy page performe performed?

Yes 2 No funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes 2 1 No ျု 1 Inpatient 2 Z ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital c within 24 hours at To the Funeral D completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ong D0055148 5/14/2012

Registrar
DHMH 17 Rev 06-2011

State

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Silver Spring, MD 20910

1500 Forest Glen Rd.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Delroy Anglin, M,D.

31. Date filed (Month, Day, Year)

MAY 18 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Connie J. Fair May 4:00A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 413 University Drive Waldorf Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 297-38-2992 Director 1 🗆 M 2 💢 F 11/25/1934 Kentucky 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20602 <u>413 University Drive</u> 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Health Aide Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked c ၉ Merrill Stella Donaldson Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 University Drive, Waldorf, MD 20602 Pamela S. Brandts/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 5/15/2012 Edgewater, Maryland 4 Dopation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 art 1. Enter the dise, e, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Chronic Airway Obstruction Medical resulting in death) Due to (or as a consequence of): Examiner Myastenia Gravis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) After this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit ause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 XXNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🎇 No မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 N Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D28352 May 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. P.O. Box 1703 La Plata, MD 20646

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Mo.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#5perfuneralhome5/17/2012/ccdoh/ba
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mont 15/2012 Year 6:10 Alfred Fontaine рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Laurel Prince George's Examiner Cherry Lane Nursing Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Months Days Hours Min. 5*/119/1*4938 **Director** 2313831486 1 M 2 D F 73 Virgínia 28a-f show 10a. State City, Town or Location 10d. Inside City Limits must be notified at Director MD Prince Georges Lanham 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6827 Forbes Blvd. 20706 U.S.A. "natural", or items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, event, the Medical Examiner Black, White, etc by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Manufacture Laborer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Department of Health and Menta Important: If item 27 is marked any injury or other traumatic energy in the property of the property o 2 Iris M. Hailey Floyd C. Fontaine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6827 Forbes Blvd. Lanham, MD 20706 Samuel Fontaine, Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Carver Memorial 5/23/2012 Martinsville, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fayette St. Martinsville, Home VA 24112 huke 301 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final nd Onset and eath Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be de þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has s certificate has director, page 2 perform 2 🗶 No 1 Yes Yes 2 Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) MAY 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 aurof Bowie Kel. SYEN 5+208 1 7 2012 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 2012 Ronald Gage 11, 6:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens at Friendship Chevy Chase Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
Jan. 19, 1919 **Funeral** 9. Birthplace (State or Foreign 1 😾 M 2 🗆 F Months Days Hours Director 714-18-7863 93 Rhode Island Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Md. Chevy Chase 1 by Yes 2 No Montgomery 10e. Street and Numbe ò 10g. Citizen of What Country? Funeral 23a 5555 Friendship Blvd. 20815 USA items ; hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 ☑ Yes 2 □ No 1941— If Yes, Give Year or Dates. 1946 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Completed 3 XWidowed 4 Divorced Specify: 1946 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Intelligence C.I.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ೭ James Ostrotsky Kathleen Murrav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Geoffrey Gage / Son 11417 Summerhouse Ct., Reston, Va. 20194 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Purial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gate of May 17,2012 Heaven Silver Spring, Md. uner a 9 21. Signatus 22. Name and Address of Facility DeVol Funeral Home MO1315 22 Wisconsin Ave., NW., Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician disease or condition resulting in death) Aspiration Pneumonia Days Medical Due to (or as a consequence of): **Examiner** Dysphagia Years Sequentially list conditions, if any, leading to immediate tauce Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cerebrovascular Disease Years that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 🗌 No the g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial fibrillation, Coronary artery disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has performed? death? 1 ☐ Yes 2 🗓 No ithin 24 hours after death.

• the Funeral Director: After this certific ompleted filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted
4 Nursing Home 5 Residence 6 Other (Specify) Living 2**X** No Hospital Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred **X**Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D34590 May 14, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy E. Fried, MD., 7758 Wisconsin Ave., #211, Bethesda, Md. 20014 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Barbara Kate Carr Grimes 2012 10:45 P™ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Spa Creek Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Director 214-05-1532 1 □ M 2 🚺 F 101 May 5, 1911 Maryland Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Director Maryland | 1 ☐ Yes 2 🕅 No Riva Anne Arundel the 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 3061 Riverview Road 21140 USA items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 Married and Mental Hygiene. Is marked other than "natural", or 仑 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 Midowed 4 □ Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Postmaster U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Annie R. Clark Charles Carr and 2 should be Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Roy Grimes/ Son 3061 Riverview Road, Riva, Maryland 21140 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baldwin UMC Cemetery 5/17/12 Millersville, MD 21. Signatura Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. et and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No 1 Yes 2 9 Unknown Division of Vital Records, P.O. been signed the should be detected Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifier 29d. Date signed (Month, Day, Year) Hung T. Øavis, M.D. (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 17,18, per FH, G928,67472012, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 Day 2 Bernice L. Green Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 1605 Aragona BLVD Fort Washington 9. Birthplace (State or Foreign Country) Arlington, V. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 F 11/03/23579-38-4521 88 Director Usual Residence of Decedent of Merial Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 1 Yes 2 □ No Prince Georges Fort Washington ۵ 10e. Street and Number 10g. Citizen of What Country? Funeral 20744 USA 1605 Aragona BLVD Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communication Specialist Federal Gov. other traumatic event, 17. Father's Name (First, Middle, Last) **Benjamin** 18. Mother's Name (First, Middle, Maiden Surname) **Luella Honesty** Brice <u>Melvin Shorts</u> <del>Lucille Duncan</del> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Aragona BLVD Fort Washington MD, 20744 Margo Jackson/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Maryland National Mem. 5/18/12 4 Donation 5 Other (Specify) Laurel, MD Signature of Funeral Service License 22. Name and Address of Facility Tyrone J. Young Funeral Services MO1476 Eads Street NE Washington DC 20019 o not enter the mode of dying, such as cardiac or respiratory arrest at caused the deat Approximate Interval Between 23a, Part 1 Part 1 Enter the disease, or co shock, or heart failure. List only ter the disease one cause or each line. Onset and Death Immediate Cause (Final disease or condition Physician/ ECC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Year Month Day Yes 2 No 1 Yes 2 1 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No Yes 2' No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c, License number erson who completed cause of death Item 23a) (Type, Print) GM,CO Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Month ROBERT LOUIS HIGGINS 14. 4:18 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
April 30,1919 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours Min. 93 292-10-1707 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | Montgomery 1 X Yes 2 □ No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Russell Ave. #908 20877 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced War II White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Trade Association Elementary/Secondary (0-12) Electrical Engineer Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Higgins Rosella Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melinda Vincent 7218A Farm Meadow Court McLean, VA 22101 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Alexandria, VA Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death ventricular Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): hypoxic Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last lung cometer Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) buting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ethision 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an (Specify)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, III

Physician

/Medical

**Examiner** 

Directo

Funeral

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Completed

Be

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**Funeral** 

Director

nd other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

death with the Maryland

Maryland 21215-0036

Baltimore,

Examine

Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnishtranish attending physician and for use as the burial transi

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230
Part II. Other significant condition malignant ple	

ted by	malignomt ple w	1 Yes 2 No 3 Probably 4 DUN				
Complete			24a. Was an autopsy performed? 1 □ Yes 2 → No 24b. Were autopsy findings available prior to completion of cause death? 1 □ Yes 2 □ No			
Be	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)			
To	1 Styles 2 No	Hospital: 1 → Hopatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)			
ation:	27. Manner of Death  1	(Month, Day, Year) Injury Work?  M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred			
Certifica	3 Suicide 6 Could not b 4 Homicide determined		Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier
(Check only
one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

20562

29d. Date signed (Month, Day, Year) May 14, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MM J Levin, 10215 Pernwood

Bethesda, Maryland

	State
Reg	istrar

Medical

31. Date filed (Month, Day, Year) WAY 16 2012 Registrar's Signature

10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 12:15 p.M Alfred Sumner Hack May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** St. Mary's California 45830 Patuxent Lane Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. (Month, Day, Year) Hours 1 🔀 M 2 🗆 F **Director** 579-22-9353 Yrs 86 09/12/1925 New York Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland St. Mary's California 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral United States 20619 45830 Patuxent Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Nidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Law Enforcement Detective Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maude Morrey John Jacob Hack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20639 Beverly H. Bess/Daughter 165 Miss Sams Way, Huntingtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Cre 05/23/2012 | Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kathleen Santivasci 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MMONARY FIBRESI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examinet Due to for as a consequence on it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy been signed by the atter should be detached for i in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILATION ATRIAL 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home XX Residence 6 Cther (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending ours after death.
seral Director: Aft
filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

DHMH 17 Rev 06-2011

State Registrar (Check

29b. Signature and till

John L.

31. Date filed (Month, F

of certifier

Bennett,

MAS

Donnett 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

23263 By the Mill Road, California, MD

00019052

29d. Date signed (Month.

20619

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAMIE LEE HALE 2012 3:30  $\mathbf{A}^{\mathsf{M}}$ May Medical 4c. County of Death a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Country) 578-52-9632 **Director** 1 🗌 M 2 🕱 F July 27, 1939 SOUTH CAROLINA Usual Residence of Deced or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be ns 23a / Funeral 5213 14th Street, NW 20011 USA items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Hygiene. other than "natural", or iten ent, the Medical Examiner i Black, White, etc. by 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of wark done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) FDIC - Government Computer Analyst and Mental Hygie is marked other Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked မ Myrtle Ellison Haywood Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derrick Smith - Son 5213 14th Street, NW, Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Chesapeake Crematory 05/18/2012 Beltsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home permit. 21. Signatury of Funeral Service Lic 716 Kennedy Street, NW, Washington, DC 20011 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nter the ck, or heart failu ly one cause on each line Onset and Death bsis Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) **Examiner** Shock Se phr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events ig physician and as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day ō Pregnant at time of death ed by the a detached i Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas performed' 1 🗌 Yes 2 🗆 No this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28b. Time of 27. Manner Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 atural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20060100 05-12-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

State

Registrar

Eas L

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BLIB

32. Registrar's Signature

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2012

filed (Month, Day, Year) MAY 18 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 430 Medical Howard James Samuel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany <u>WMHS-RMC</u> Cumberland Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, Year) Jan 17, 1951 Director 1 XM 2 F 218-60-0525 61 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Oldtown MD Allegany 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21555 USA 18405 James Hill Way SE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 і XNo Specify: "natural", Specify. 3 Widowed 4 Divorced white Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ June L. Piper Samuel Howard James, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau WV 26722 PO Box 75 Green Spring Sharon Steward sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other Specify) 3 Removal from State Hartsock Cemetery Oldtown MD 22. Name and Address of Facility
Scarpelli Funeral Home, PA f Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 X No Yes 2 XN 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 **N**O 1 Tes မ 1 📈 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No Investigation the Funeral Director; appletely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nume Practitioner To the best of any knowled 29b. Signature and title

Registrar DHMH 17 Rev 06-2011 MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

68455

12501 Wilburbrook Rd. Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

5,3,12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Hobert Herbert Johnson 9:45a M May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Myersville 12509 Spruce Run Road Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Days Hours Oct.16, 1930 Director 217-28-0916 Maryland 81 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Myersville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12509 Spruce Run Road 21773 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. þ "natural", or 1 Never Married 2 X Married 1 Yes If Yes, Give 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Fabricator 6 Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Wellington Johnson Rosa Catherine Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Lois Johnson/wife 12509 Spruce Run Road, Myersville, MD 21773 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) ō injuny Grossnickle Brethren May 29,2012 Myersville, Maryland 21. Signatus 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition 014 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last has been signed by the attending physician e 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No ☐ Accider☐ Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18/ 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 291

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 1 2012

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <sup>Day</sup> 2012 14, ам May 9:50 Lionel Jean Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5435 MacBeth Street P.G. Hyattsville If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Country 220-26-0937 **Director** 1 5 M 2 D F Sept. 24, 1949 Haiti 62 Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 K No MD P.G. Hvattsville 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 5435 MacBeth Street 20784 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married þ Specify: Black Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: If Yes Give "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Waiter Hotel Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဂ Leon Jean Julia Guerrier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Marie Ghislaine Jean/Wife 5435 MacBeth Street, Hyattsville, MD 20784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 26, 2012 20c. Location - City or Town, State 1 🛮 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Bladder Cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter or certying Cause (Disease or injury Due to (or as a consequence of): and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permist. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year the a Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed

Division of Vital Records, P.O. Box 68760

autopsy performed? 2 No

24b. Were autopsy findings available prior to completion of cause of death? 2 No

26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

Calverton,

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifie Louatchou, MD Jocelyne

28a. Date of injury (Month, Day, Year)

29c. License number D63740 29d, Date signed (Month, Day, Year)

May 14, 2012

MD 20705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, MD 4041 Powder Mill Road,

31. Date filed (Month, Day, Year) State Registrar

Be

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Certificate:

Medical

25. Was case referred to medical

2 X No

5 Pending

MAY 1 6 2012

Investigation

determined

6 Could not be

examiner?

27. Manner of Death

1X Natural

Accident

Suicide

4 Homicide

2. Registrar's Signature

Ö

28b. Time of

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month-Day Year WIN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death County of Death ANNE ARUNDEL ANNAPOLIS Anne Arundel Medical Center Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours **Director** 170-22-0583 1/2M2 | F December 9 84 Brooklyn, NY show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Anne Arundel Annapolis 28a-f MD Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7101 Bay Front Drive 21403 USA and 2 should be filed within 72 hours after death wealth and Mental Hygiene. 12. Was Decedent Ever in U.S.
Armed Forces? Not

1 Xyes 2 No
If Yes, Give Available 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. "natural", or þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) vice president Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Jacobson Yetta (Gertler) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 (SON) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Jacques Jacobson 248 Pennsylvania Avenue Reading, PA 19606 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Sinai Cemetery | 05/12/2012 | Shillington, PA Advent Funeral Services, 42 Hudson St #110
Annapolis MD 21401 21. Signature of Funeral Service Deensee Melanie Hurawa 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END RENAI AGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SIOTAMMAJOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atte d be detached for Pregnant at time of death Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? this certificate Yes 2 No the funeral director, **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital ဂ္ 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending P n 24 hours after death. e Funeral Director: After t Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 ☐ Sulcide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 To the P 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HWY, ANNAPOUS, M.D. 21401 11+1 gistrar's Signature

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Lillian Maria Johnson May 2012 6:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 41450 Knight Road Leonardtown St. Mary's 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number If Under 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days (Month, Day, Year) Director 213-22-2192 1 M 2 X F 93 Maryland 07/13/1918 Usual Residence of Decedent show at 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-fs event, the Medical Examiner must be notified 1 Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20650 USA 41450 Knight Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black White etc þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify. Specify: White If Yes, Give 3 K Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Rosalie Cooper James Ernest Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Mary Cecelia Vaughan/ Daughter 48028 Mary Lynn Drive Lexington Park, MD 20653 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Charles Memorial Grds 05/25/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility — Gardiner Funeral Home, P.A. Mattingley—Gardiner Funeral Home, Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ATHEROSCIENCETIC CAMMOVASCULAR MIGHE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) WEEKS **Examiner** OWEL Sequentially fist conditio if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

A Pregnant at time of death

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year been signed by the should be detached 1 ☐ Yes ∠ ₹ Unknown Hospital or Attending Physician; The law requires that the by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TO BRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 Yes 2 No eral Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practition or 15 the cest of my knowledge, death occurred at the fine date and place, as a close to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 16096 MD

St

Registrar

SMAM ASCOCIATES

GILV

32 Registrar's Signature

HULYWOD, 141) 20676

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5-

PAJUNDER

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Una Imogene King 2012 12:15 AM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Broadmore Senior Living Hagers town Washington 5. Social Security Numbe 7. Age (In vrs. last birthday) r If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 M 2 F 220-42-5523 89 Director Maryland 9 1923 Feb Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 23a or 28a-f Smithsburg 1 Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral permit. Page 1 and 2 should be flied within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic 21783 U.S.A. 4058 Forrest School Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Completed by Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Claude C. Lewis Annie Hays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12044 Pleasant Walk Rd. Myersville, Maryland 21773 John W. King (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garfield United May 28, Garfield, Maryland Methodist Church Cem. 2012 Signature of Funeral Service License 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementon disease or condition resulting in death) Advanced Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? ŏ Pregnant at time of death Month Day Year detached g 🔲 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HTN, CVA, A-fob, atherosclerosis, Osteopenon, Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown DID, TKR, jeft mastord effasion, Visual impairmenta. Was an autops, 24b. Were autopsy findings available prior to completion of cause of has performed' death? stusis dermatitis 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? DISCHONGER 1 ☐ Yes 2 ☑ No 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTE > 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R155338 24, 2012 Nermandes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EUNJU HERNANDEZ 340 Mili ST HAVERSTOWN MD 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#9and#12perfuneralhome5/23/2012/ccdoh/ba
Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05 Month Physician/ 2012 A M 4:02 Henry Newell Kilgore Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Center Clinton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) Tennessee **Director** 414-28-2767 1 **X**) M 2 □ F 87 09-02-1924 Usual Residence of Decedent Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 🔀 No Prince Georges Brandywine Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20613 United States 11721 Redwood Drive East 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 ☑ Yes 2 ☐ No If Yes, Give 1944–1946 Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Printer Proof Reader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ella Kate Scott Ted Roadman Kilgore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11721 Redwood Dr. East Brandywine, Maryland 20613 Louise S. Kilgore/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-15-2012 Charlotte Hall, MD Brinsfield-Echols Signature of Funeral Service Licensee 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A M00945 St. Mary's Ave. La Plata, Maryland 20646 211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physi i n disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ò in the past 12 months? Month Day Year be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? After t 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director; Al Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 06-2011

who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For	State of N	/larylan	id / Depa	artment of	Health	and M	1ental Hy	giene	)				
			1 - State Registrar	Cer	ertificate of Death Reg. No. 2				20	12	)	74				
I	Physicia		1. Decedent's Name (First, Middle,	Last)	6					2. Date of De Month	eath Da	¥ 2%	ear (7/1)		of Death	М
-	Medic Examir		4a. Facility Name (if not institution,	give street and number,			4b. City, Town,	or Location	of Death			c. County of	1	10.0		_
-	,		Mandrin Inpatie	nt Care Cer	iter		Harwood	i			A	Anne A	rund	le1		
	Funeral Director		5. Social Security Number 401-42-3072 Usual Residence of Decedent	. D., W	ige (In <i>yr</i> s. Ia 1 <b>9</b>	ast birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Bir (Month, Da 6/8/19	y, Year)		Count		e or Forei	gn
	and show	힏	10a. State 10b. County		10c. Cit	y, Town or Loc	cation						10	d. Inside	City Limi	ts
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	th the		10e. Street and Number	1			10f. Zip Code				10g. Ci	itizen of Wha		:ry?		
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9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	Armed Forces	2	H	Vas Decedent of f Yes, specify Cui ☐ Yes 2 🛣 N	ban, Mexica	an, Puerto	Rican, etc.)		14. Race - A Black, N Specify:	America White, e Whi	tc.		
5-0	2 hou "natu edical	plet	15. Decedent (Specify only highes				ent's Usual Occi		st of worki	na	16b. K	(ind of Busin	ness/Ind	ustry		_
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<b>d</b> 2	filed wi al Hygie d other	Be (	17. Father's Name (First, Middle, La	st)		Secre	etary	18. Motl	her's Name	e (First, Middle,			riai	утап	u	_
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Baltimore,	je 1a nt of H If ite or oth		20a. Method of Disposition  1 XI Burial 2/ Cremation	3  Removal from State	. 0	emetery, crem	sition (Name of natory or other pl	ace)		Date .		ocation - Cit				
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	Medical Examiner		resulting in death)	Due to (or as	onsequ	ience of):	1-1	, , , ,	71700	TIC	7 10		+	2	1)	
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	artifica ding pl	w	IF FEMALE:	220 If use outcom	n of progna	n					T					_
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transion.	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknown	2 Feta at time of d	ıl death 3 🗌	Ectopic pregna Other (specify)	ncy				23d. Date o Month		ry Day	Year	
P.O.	requires that the des been signed by the s should be detached	by PI	Part II. Other significant condition	s contributing to death	but not res	ulting in the ur	nderlying cause (	given in Part	t I.	23e. Did to	obacco u	use contribu	te to the	cause of	f death?	
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ita	Physician: The this certificate eral director, pag	Be o	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:			Ot	Place of Dea	,			MAN	Dili 1	10 77	UFI	
of V	g Physer this eral d	e: To	27. Manner of Death	28a. Date of inj	ury	ER/Outpatient 28b. Time of	t 3 🗌 DOA 28c. Inju	4 ⊔ N		me 5 🗌 Resid 28d. Describe h		Other (S	pecify)	CA	REC	-11
Ou	Attending F death. ctor: After t y the funer.	icat	1. Natural 5 Pending 2 Accident Investiga	ition	ay, Year)	injury	M 1 [	rk? ☐ Yes 2 ☐	_			,				
Division of Vital Records,	al or Attend s after death il Director: P ed in by the f	l Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of In	jury - At ho tc. (Specify)		et, factory, office		2	28f. Location (S City or Tow			r Rural F	Route Nur	mber,	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of Jurse Practitioner:	examination	and/or investi	gation, in my opir	nion, death o	occurred at	the time, date a	ind place	, and due to	the caus	se(s) and n	manner sta	ited
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Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAL Physician/ 0220 <u>Mary Jean Loqan</u> Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ARTOR AVRE (JRAUE URSING Home 8. Date of Birth (Month, Day, Year) March26,1925 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Min Hours 1 ☐ M 2 🔀 F 87 Maryland **Director** 216-48-4545 Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No Havre de Grace Harfrod MD 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A Street 21078 320 South Stokes\_ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes Completed by Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Disable</u>d Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Ellen Morton Evan T. Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stokes St., Havre de Grace, MD <u> Pamela B. Crouse (Niece)</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/19/2012 Aberdeen, MD Harford Mem.Gdns 22. Name and Address of Facility of Funeral Service License Zellman Funeral Home, PA Washington St., Havre de Grace, MD S. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pregnancy 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknow Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by iknown 1 ☐ Yes 2 ☐ No 3 Probably 4 Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medical 26. Place of Death heck only one) Be Other: MARY Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA irsing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Man er of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation
6 
Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) onth, Day Year) e and title of certifier 29d. Date

Registrar

DHMH 17 Rev 7/2009

State

2028

person who completed cause of death (Item 23a) (Type, Prin

Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bay CHARLES LINTHICOM May 2012 8:45 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Center Cambridge Dorchester 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1933 1 🔀 M 2 🗆 F March 8. 214-32-1365 Yrs Maryland Director 79 Usual Residence of Decedent 28a-f shov 10a. State 10b. County or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits **Funeral Director** MD Dorchester Cambridge 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 2910 Pungy Path 21613 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ₺ Yes 2 □ No
If Yes, Give Year or Dates. 1956-58 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify: white "natural", Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 6 waterman seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas G. Linthicum Agnes Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara G. Yost p.r. 209 Brohawn Avenue, Cambridge, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva: 5/11/12 Delmar, DE are of Funeral Sen 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final CACHEXIA Onset and Death Physician/ IRREVERSIBLE NATURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner To THRIVE FAILURE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 2 No by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕦 Unknown 24b. Were autopsy findings available prior to completion of cause of death? as e 2 certificate ha performed Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospita Other: 2 **P** No ြု 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending М 1 🗌 Yes 2 🗌 No after death

Director: A

in by the f Accident Investigation 🗀 Accider 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hospital within 24 hours a To the Funeral C completed filled Medical 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

Registrar

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JEEVAN ERRABOLU

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

503

D69234

CAMBRIDGE

STREET

05,10,2012

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09 2012 05 4:01 Α Μ. Lessane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Months Hours Min (Month, Day, Year) Director 1 □ M 2 🗓 F 94 577-28-7267 08/28/1917 DC Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits at 10a. State 10b. County Director Examiner must be notified 1X Yes 2 ☐ No DC Washington with the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20011 USA 313 Emerson St. NW or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify Specify: **Black** 'natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) within 72 and Mental Hygiene. Department of Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Agriculture Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ pe Frances Mc Coy Authur Dunn Page 1 and 2 should I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 313 Emerson St. NW Washington, DC 20011 Eugene Lessane/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State injury or 05/17/2012 4 Donation 5 Other (Specify) Lincoln Cemetery Suitland, MD 22. Name and Address of Facility Marshall-March Funeral Home ure of Faneral Service Licen anyi 4217 9th St. NW Washington, DC 20011 un Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last burialphysician Physician/Medical P.O. Box 68760 the attending yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consert at time of death 5 Other (specify) IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months? Month Year Day signed by the a Id be detached f Yes 2 X No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 : performe 2 🗌 No ☐ Yes 2 No certificate Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 ANO ပ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient this After this funeral c 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 47867 person who completed cause of death (Item 23a) (Type, Print) #216. Rockylla 4701 Kandolph

State Registrar

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31. Date f

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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Michael Examiner.	-{	2) Signature of F	uneral Service L	icensee			11750		ir Po	E. F.	Lassa	ahn will	Funeral e Mary	Home, P.A. land 21087
Physician	$\dashv$		the disease, or only one cause of	omplications that cause	ed the death.	Do not	enter the mode	e of dying	, such as ca	rdiac or res	spiratory arr	est, sho	ck, or heart	Approximate Interval Between Doset and
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ing Physician: The law requires that the death certificate be ex.  After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial.	Sicie	1 Yes 2		7	at time of de	ath 5	Other (Sp	pecify)		of all				
C. B.	Physic	Part II. Other sign	nificant condition		ath but not re	sulting	in the underlyir	ng cause	given in Par	rt I.	23e. Did to	obacco (	use contribute to	the cause of death?
P.O.	9	Cardio	omegaly								1 Yes	2	No 3 Prol	cably 4 🔀 Unknown
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of Vital Records, ng Physician: The law requir ther this certificate has been s nneral director, page 2 should	Completed										perfo 1 ✓ Yes	rmed? 2 No	death? 1 ✓ Ye	es 2 No
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burn	cation:	27. Manner of Dea	ath 5 Pendi	28a. Date of li (Month, Day	njury y,Year)	28b. Ti	me of Injury		ury at Work? Yes 2		d. Describe	now inju	иу оссипеа	
Division  To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fu	ifical	2 Accident 3 Suicide	6 Could	not be	Injury - At ho	ome, fari	m, street, facto	ry, office	building, etc	28	f. Location (		nd Number or Ru	ıral Route Number, City
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he Ho in 24 l		29a. Certifier 1 (Check only one) 2		ysician: To the best of niner: On the basis of e	my knowled xamination a	ge, deat nd/or inv	h occurred at ti vestigation, in r	he time, o my opinio	date and plac n, death occ	ce, and du curred at th	e to the caus e time, date	se(s) an and pla	d manner as stat ice, and due to th	ed. e cause(s)
To t with To t	Medical	29b. Signature an		and manner state					se number				Date signed (Mo	
		Dat	<u> </u>	Pago.	_			O.C	.M.E.			May	25, 2012	
		30. Name and add	dress of person	who completed cause of	f death (Item	23a)			-					
		Patricia Ar	onica-Pollak	MD. Assistant	Medical I	Exami	ner 900 V	Ν. Balti	imore Str	eet, Balt	timpre, M	D 212	23	
Sta Regist		31. Date filed (Mo	1th, Day (Ygar)	Several 32. Regis	par's Sign tu	ire de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY G927 5/31/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5-04 Physician/ Month JOSEPH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WESTERN MARYLAND HEALTH SYS CUMBERLAND 10 ALLEGAN Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country). **Funeral** 8. Date of Birth Hours <sup>(Month, Day, Year)</sup> Aug 19, 1936 Director 1 XM 2 □ F 234-56-5371 75 show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Allegany Cumberland MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 11618 Bierman Drive 21502 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
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Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ ARD: AC ARRHTTANIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 4P ERTENTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be 7010 12001 P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No Yes 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director; After this etely filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical within 24 hour To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0036371

State Registrar

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31. Date filed (M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY Tay 2012 MYRNA MOBLEY 9:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BETHESDA MONTGOMERY WALTER REED NATIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **8**0 Yrs. 8. Date of Birth Social Security Number **Funeral** 1 □ M 2 🗶 F Months Min 428-50 Hours 0235 **Director** USSISSI PPI Usual Residence of Deceden 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Maryland must be notified at Funeral Director D 1 XYes 2 ☐ No WASHINGTON 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? 23a5030 - 10" STREET 20017 USA items permit, Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced BLACK Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE of Health and Mental Hygiene item 27 is marked other the other traumatic event, the NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, မ WOMACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health ADELPHING 20183 UDY AUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Department of h Important: If ite any injury or ot once, 1 Burial 2 Cremation 3 Removal from State ADELPHI, MD 05-16-2012 4 Donation 5 Other (Specify) BIANCHI FUNERAL SERVICE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H01257 814 UPSHUR STREET NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): sician and burial-transit I or Attending Physician: The law requires that the death certificate be executed after death. that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No 2 X N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 **X**No ပု 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 🗌 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature 29d. Date signed (Month, Day, Year,

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DHMH 17 Rev 7/2009

State Registrar MARY A.

filed (Month)

ANDREWS,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MEDICAL CENTER

VA 0101248160

BETHESDA, MD, 20889

MAY, 10, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Nicholson David Ogier May 8 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Marlboro Prince George's 9514 Nottingham Drive Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month. Dav. Year) Hours Min. Country) **Director** 1 🔀 M 2 🗆 F 030 30 2780 72 March 23, 1940 Boston, MASS 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 📈 No Maryland Prince George Upper Marlboro 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 9514 Nottingham Drive 20772 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Was Deceue...
Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Specify: Completed 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Supervisor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Morris John Nicholson Marjorie Gwynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Gilman (daughter) 2210 Green Valley Drive, Sunderland, MD 20689 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 5/9/2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signatur of Funeral Sovice Licensee ot Hel MU1391 Ferry Road, Clinton, MD 20735 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician Pancianic Concer Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on. To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atter in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe Yes 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral: 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Director: Aft 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5(024 May 9 2012 20678 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick Suite 110 Abbett 110 Hospital Road Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elmer Ray Propst Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Cumberland Allegany If Under 1 Year If Under 24 Hrs 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 215-18-8028 **Director** 1**X** M 2 □ F 93 02/01/1919 Maryland Usual Residence of Deceder 28a-f show 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at 10a. State Director 1 XYes 2 No MD Cumberland Allegany 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 21502 USA 912 Kent Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14 Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No 1943-If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 Married Yes Give þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: "natural", 3 X Widowed 4 Divorced Completed 1945 Year or Dates White the Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry عد filed with... عا Hygiene. عاد than "r Elementary/Secondary (0-12) College (1-4 or 5+) age 1 and 2 should be filed within of Health and Mental Hygiens It. If item 27 is marked other they or other traumatic event, the Hauling 12 Truck Driver Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Propst Thompson Charles Andrew Lucy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 11901 Valley Road, NE, Cumberland, MD 215 21502 Mary Louise Slonaker / Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Hillcrest Mem. Park Important: If any injura 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/10/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home. 404 Decatur Street, Cumberland, MD 21502 20 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to one cause on each line. Approximate Interval Between Onset and Death 3 day S 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Month Pregnant at time of death 1 Yes 2 L 9 Unknown P.O. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 호 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed I or Attending Physician: The law after death.

Director: After this certificate has ! page 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Hospital Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Griffying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 3 certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

Registrar

DHMH 17 Rev 06-2011

State

625 Kent Avenue, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sunil K. Gupta, M.D.,

31. Date file (Aryth 0°9 Y2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Richard Powell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland Western MD Regional Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth . Birthplace (State or Foreign **Funeral** Days Hours Min (Montuly 17 a 1946 Maryland 65 219-46-2467 Director 1**X** M 2 □ F Usual Residence of Decedent show of Health and Mental Hygiene. iden 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frostburg Maryland Allegany 1 X Yes 2 ☐ No 10e. Street and Number 4 Maple Drive 10f. Zip Code 10g. Citizen of What Country? U.S.A. Completed by Funeral 21532-Department of Health and Mental Hygiene.
Important: If item 27 is marked other the ""

any njury or other traumet:

Once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Victoria 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Driver Be 18. Mother's Name (First, Middle, Maiden Surname) **Lola V. Frost** 17. Father's Name (First, Middle, Last) ပ္ Huey W. Powell Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of 3022 Green Gables Dr. Ridgeley r Town, State, Zip Code) **West Virginia 26753-**Ridgeley Huev W. Powell Jr. brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place)
Cumberland Crematory Cumberland Maryland May 09, 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 meral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Phytician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury STENDEMINA and burial-trar that initiated events resulting in death) Last by the attending physician stached for use as the buria Completed by Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown NESSIVE PISONDER 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform 1 Yes 2 2 No 1 Yes 2 No To the Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medi-To Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Hospital Other: 2 HNO 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner o ath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Hatural Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours a the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the ignature 5+ ddress of person who completed cause of death (Item 23a) (Type, Print)
mes Raver, 900 Seton Drive, Cumberland, MD 21502 James Raver, 31. Date filed (Mor 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 11:55P M May 20°1"2 Thomas Parker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate Hospice House If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Dec 20 Hours Min. 1960 Maryland 217-78-6506 Director 1 M 2 - F 51 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No MarylandPrince George's Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20774 3817 Endicott Place filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. 1 Never Married 2X Married ρ 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Self Employed 4yrs Home Improvement n and Mental Hygien is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Victoria Grissom e 1 and 2 should be in of Health and Mental item 27 is marked in other traumatic e Thomas Parker Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3817 Endicott Place Springdale, Md. Greer Parker(Wife) Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Bees to come of cemetery, crematory or other s 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Park 5-18-12 Annapolis, Md. 4 Donation 5 Other (Specify) Amene a Recese of Seilit Sons Mortuary, P.A. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ! as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performe death? 1 Tyes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred eral Director; After filled in by the funer (Month, Day, Year) injury 5 Pendina Natural
Accident 1 Yes 2 No death investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartiforn Nurse Fractitioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F Cartifying Nursa Fractitioner: To the bist of my Howledge 29d. Date signed (Month. Day, Year) 29b Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

5501

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Susan Addie Pickeral Physician/ 18 2012 9:26 A.M May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death St. Mary's St. Mary's Hospital Leonardtown 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours Min. 1 M 2 X F 62 01/27/1950 Virginia **Director** 228-72-1277 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 X No Lexington Park Maryland St. Mary's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20653 IISA 17823 Rosecroft Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian er than "natural", or iter the Medical Examiner Black, White, etc. 1 Never Married 2 X Married Completed by ☐ Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Genevieve Rush Wilson Benjamin Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 20653 17823 Rosecroft Road Lexington Park, MD Doug Wayne Pickeral/ Husband other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o Mattingley Gardiner place) ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Funeral HomeP.A.Crematory 05/21/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Martingley-Gardiner Funeral Home, P.A. Signature of Funeral Service Liga 41590 Fenwick Street Leonardtown, MD 20650 23a. Part/i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MctASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): 10453 Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence or) ii any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and. burial-trans Due to (or as a consequence of): resulting in death) Last attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? 2 No 1 Yes To the Hospital or Attending Physician: Vital 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ot 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Natural 5 Pending Division 1 Tes 2 No Accident Investigation Could not be after death Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifier 29d. Date signed (Month. Dav. Year) (Itom 23a) (Type, Print) 30. Name and address of person who completed cause William Michael Mahaffey, MD 25480 Point Lookout Road Leonardtown, MD 20650

State

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Registrar

31. Date filed (Month

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 2 Date of Deeth 1. Decedent's Neme (First, Middle, Last) Month 16 2012 City, Town, or Location of Deeth 4c County of Death (If not institution, give ITUTI If Under 24 Hrs. 8. Date of Birth Month, Day If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number 6 Sex Days Hours Months 10 M 2□ F Yrs. Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 ☐ Married Specify: [] 1 Yes 2 No Specify. Inite 3 ₩idowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surr 17. Father's Neme (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21632 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 3115. Main St. Federals burg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonitis ASPIRATION Due to (or as a consequence of): sphagia Due to (or as a consequence of): ACC. DENT Cerebral Vascular Due to (or as a consequence of): 50 Hyperkusion 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autops performed?

Physician /Medical Examiner Medical Certification: To Be Completed by Physiclan/Medical Examiner

within 24 hours efter deeth.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit To the Hospital or Attending Physician: The law requires thet the death certificete be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylend Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

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Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Part II.	Other significant	conditions con	tributing to death	but not resulting	in the underlying ca	use given in Part I


у	24b. Were autopsy findings available prior to
	completion of cause of deeth?

1 ☐ Yes 2 No

MD 21655

25.	Was case examiner?	/	to medical	
07	Mannerof	Dooth		_

		26. P	Place of Death (Cl	heck only one)	
tient	3□ DOA	Other: 4	Nursing Home	5 Residence	6 □Other (Specify)
e of	28c.	Injury at	28d.	Describe how inj	ury occurred

7. Manner of Deeth	
1 Natural	5 Pending
2 Accident	investigation
3 ☐ Suicide	6 Could not be determined
A COLUMN TO STATE OF THE STATE	

1	(Month, Day Yeer)	-
1		
-		

1 Inpatient

Time of njury		28c. Injury at Work?	
	М	1 ☐ Yes	s 2 No

28d.	Describe	how injury	occurred	

1 Yes 2 No

9a. Certifier	12 Certify

4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Sign	ature and t	itle of c	ertifier	0	
	1.	h	0	X	-

29c. License number

2 ER/Outpa

29d. Date signed (Month, Day, Yeer)

/wo Th 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

1)53253

05-18-12

IIMoth 31. Date filed (Month, bay, State Registrar

Sniezek . Registrer's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:37 PM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Prince Regional Hospital Laurel George Laurel If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 243 40 5037 88 Director 1 XM 2 F 10/27/1923 NC oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 461 H Street NW 20001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Worker Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Geneva Williams Caswell Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Colbert Phillips/Nephew 2016 Leggett Rd. Rocky Mt., NC 27801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garden of Geth.Cem 5/21/2012 Rocky Mount, NC 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) ture of Funeral Service Licens 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Tachycardia Ventricular Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Acute Respiratory for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physiciar Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 | Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 2 🗌 No this certificate 1 Yes • Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Investigation Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0012962 May

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State Registrar

20RAY

31. Date filed (Mor

DA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

legistrar's Signatur

Laurel Regional Hospital

Van Dusen

Laurel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 5 ARNESS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death North Beach Anne Arundel 637 California Avenue Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Director 1 X M 2 🗆 F 108-22-7801 NY 09/22/1930 81 show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 - Yes 2 No Anne Arundel North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20714 United States 637 California Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black. White, etc. Completed by 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced Specify: Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eli Parness Sally Seligson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If Item 27 is Elizabeth Parness / Wife 637 California Avenue, North Beach, MD 20714 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Maryland Veteran s 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 05/16/2012 Cemetery Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Sary J. Gof1 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
United Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 014774 5-15-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HWY ANNAPOLIS, MD 21401 DRW 10 SHAHID AZIZ no. 445 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

DHMH 17 Rev 06-2011

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**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 09, 2012 07:40 AM Linda S. Ritchie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Frostburg 18139 Mt. Savage Rd Social Security Number . Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💆 F December 04, 1956 55 Maryland 215-74-0801 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland Allegany Frostburg 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18139 Mt. Savage Rd Funeral U.S.A. 21532-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 🗌 Yes 2 🔀 No Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State University House Keeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Minnie Emos Cobey Yutzy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18139 Mt. Savage Rd Frostburg Maryland 21532-19a. Informant's Name/Relationship (Type, Print) Husband 18139 Mt. Savage Rd Matthew Ritchie 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland Maryland May 10, 2012 4 Donation 5 Other (Specify) Signature of Fundal Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Canco disease or condition Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 attending p has eral Director: After the filled in by the funeral within 24 hours after death

To the Funeral Director: A

ms 23a or 28a-f show must be notified at

Baltimore, Maryland 21215-0036

	resulting in death)	Sequentially list conditions, fany, leading to immediate sause. Enter Underlying  Due to (or as a consequence of):					J
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury						
IICAI EVA	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
y stoletty into	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	s decedent pregnant he past 12 months? Yes 2 \( \text{No} \)  23c. If yes, outcome of pregnancy 1 \( \text{Live Birth } 2 \) Fetal death 3 \( \text{Ectopic pregnancy} \) 4 \( \text{Pregnant at time of death} \) 5 \( \text{Other (specify)} \)					livery Day Year
	Part II. Other significant conditions of					Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown	
					24a. Was an autopsy performed? 1 □ Yes 2 12/2	prior to death?	topsy findings available completion of cause of
0	25. Was case referred to medical			26. Place of Death (Che	eck only one)		
2	examiner? 1  Yes 2 No	Hospital: 1   Inpatient 2		DOA Other: 4 Nursing	Home 5 Residence	6 Other (Spec	ify)
1 DA	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
200	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)			ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		ral Route Number,
Medica	(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examination se Practioner: To the best of m	n and/or investigation	n, in my opinion, death occurred	at the time, date and pla	ce, and due to the	cause(s) and manner stated,
	29b. Signature and title of certifier	Jana &	/	29c. License number		Date signed (Mont.	h, Day, Year)

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

POONAI

32. Registrar's Signature

ickRamadityA

MAY 10 2012

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Reymundo Maryth 13, 2€012 2:41 A Ramos Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Prince George's 1114 Elwin Road Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 363-74-0432 1 M 2 X XF 05/05/1936 76 Usual Residence of Decedent 28a-f show 10b. County or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Ft. Washington 1 Yes 2 X No 10e. Street and Number 23a or 10g. Citizen of What Country? Funeral 20744 1114 Elwin Road USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force þ 1 Never Married 2 Married Yes 2XX No Yes, Give Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Completed 3 Widowed 4 Divorced Specify: Filipino . Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) per rit. Page 1 and 2 should be filed within 72 Decartment of Health and Mental Hyglene. Important: If item 27 is marked other than 'ampi hjury or other traumatic event, the Meaonce. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Doctor Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dionisio Alejandra Chua 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1114 Elwin Road Ft. Washington, Maryland Ramos / Daughter Marie 20744 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Kalas Crematory 05/14/2012 Edgewater, Maryland 21. Signature of Fuleral Service Lie hsee <sup>22. Name and Address of Facility</sup>George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that se shock, or heart failure. List only one cause on e the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ JNG Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last PIRATOR burial-tran physician Physician/Medical Box 68760 the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 18 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day ped 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? perforn 2 No Yes 2 Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ျ 1 🗌 Yes 2 Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director, After tl Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi eath (Item 23a) (Type, Print)

Registrar

URRATTS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 21, 2012 3:35p.mM Patricia Mary Rauner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Charlotte Hall Veterans Home If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1072471927 Nebraska 84 505-34-3694 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No California St. Mary's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20619 45266 Elmbrook Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Kaipust Zakrzewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1070 Kings Creek Drive, St. Leonard, MD 20685 Glen W. Rauner/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/30/2012 Hollywood, MD Johns Cemetery Signature of Fundial Service Disease
Michele Brinsfield M01652 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespiratory Interval Between shock, or heart failure. List only one carseron each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence or) Due to (or as a consequence of):

Physician/ Medical Examiner nei

and

attending physician a for use as the burial-

Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det

Box 68760

Division of Vital Records, P.O.

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

9 Unknown

Other signifi

For State Registrar

10a, State

Physician/

Medical

Examiner

**Funeral** 

Director

ms 23a or 28a-f show must be notified at

items death

0

"natural",

and Mental Hygiene.

permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the

Examiner

Medical

the

Director

Funeral

Completed by

Be

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Exami

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Completed

Be

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Certificate:

Medical

John

the Maryland

with

within 72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?

Part L

yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death

3 Fctopic pregnancy 5 Other (specify)

23d Date of delivery

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

performe Yes 2 No 26. Place of Death (Check only one)

24a. Was an

4 M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Year

25. Was case 1 Tyes 27. Manner of Death

Natural
Accident
Suicide

4 Homicide

28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

Hospital

contributing to

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Me real examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number of the cause is and manner as stated. 29a. Certifie (Check or ly or 29b. Signature a

4037728

death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of

determined

100 Hospital Road, Prince Frederick, MD 20678 Stephen Cafferty, D.O.,

State Registrar

DHMH 17 Rev 7/2009

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death MAY 4,2012 12:50A M Physician/ RIPPEON MAY BETTY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours 216-14-6510 97 **Director** 1 M 2 X F March 8, 1915 Maryland Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State death with the Maryland Director 1 S Yes 2 No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21793 60 West Frederick Street United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give "natural", Completed 3 Nidowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerk Retail other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental if Health and Mental Annie E. Smith Carl S. Reiley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Reiley / Sister 10210 Pine Tree Rd. Woodsboro, MD 21798 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 6, 2012 Department of H Important: If ite any injury or ot cametery crematory or other place)
Resthaven
Memorial Gardens 1 🛮 Burial 2 🗌 Cremation 3 🗎 Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

21. Signatur Funeral S, rvice Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 Enter the dispase, or complications that the dispase of complications that the cause on each line. 23a. Part 1. Enter the di shock, or heart fait Immediate Cause (Final ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death occlusion of the left lea Physician/ Acute arterial disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HUBERTUNSIUM Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Sue to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy
Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Investigation 6 Could not be the. Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

24 hours a within 2

To the comple

D0063498 \* WADUWA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West 7th St Frederick

strar's Signature

29c License number

29d. Date signed (Month, Day, Year)

State Registrar

3

(Check only one)

31. Date filed (Mont

29b. Signature and title or cert

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruskowski 12:35 AM 20 2012 Donna Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFURD MEMORIAL HOSPITAL DE GRACE HAVRE HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🔀 F (Month, Day, Year) 0/27/1956 Hours Min. Director 024-46-4495 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director MA Essex Yes 2 No Danvers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of Funeral 272 Maple Street 01923 America 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Psychologist Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked c Alfio Racca Olga Ventresca other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 01923 272 Maple Street, Danvers, Massachusetts William Ruskowski (husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Walnut Grove Cmty 05/26/2012 Danvers Mass. 22. Name and Address of Facility Zellman Funeral Home, P.A. Signature of Emeral Service B S.Washington St. Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death ARTERY DISEASE Physician/ ORONARY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown that the death Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AROTID STENUSIS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas perform 2 🗌 No Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 FR/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred s after des. •al Director: Afte 1 Natural 2 Accident 5 Pending 1 Tes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours To the Funeral I Medical 1) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month, Day, Year) D \$\$69864 MYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 S. UMOW AVE. HAVRE DE GRAE, MO 21078 CHIRMAR 7 IMOTHY

DHMH 17 Rev 7/2009

State Registrar Registrar's Signatu

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland	/ Department of Hea		giene	. 71 05					
_		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Dea	Reg. No. 2	1/435						
Physic Med	lical	James Allen	Stokes	2. Date of De Month May 11	Day Year	3. Time of Death 8:11 P M					
Exam	iner	4a. Facility Name (if not institution, give street and number)  29301 National Pike, NE	4b. City, Town, or Loca Flintst		4c. County of Death	any					
Funera Directo		5. Social Security Number 217–28–9076 6. Sex 1 🕅 M 2 □ F 80		Juder 24 Hrs. 8. Date of Bir Jours Min. (Month, Date 08/23/	v. Year) Cour	place (State o <i>r For</i> eign ntry) S <b>ylvania</b>					
d d	٦.	Usual Residence of Decedent  10a. State 10b. County 10c City T				- 11111					
arylan a-f sh fied a	Director	MD Allegany	own or Location Flintstone			10d. Inside City Limits 1 ☐ Yes 2 🛣 No					
h the Mi Sa or 28 be noti	al Dire	10e. Street and Number 29301 National Pike, NE	10f. Zip Code 2 <b>1</b> 530		10g. Citizen of What Coul						
leath wit tems 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispani	ic Origin? (Specify Yes or No-		can Indian,					
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at the Medical Examiner must be notified at the Medical Examiner must be	ē	1 Never Married 2 Married 1 X Yes 2 No 1952	If Yes, specify Cuban, Me  1 ☐ Yes 2 汉 No Spi		Black, White, Specify:						
5-0	plet	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during	and at at warding	16b. Kind of Business In	White siness Industry					
2121 within 72 giene. er than the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired)  Laborer	most of working	Tire and R	ubber					
be filed vental Hygred other	To Be	17. Father's Name (First, Middle, Last) James Abraham Stok		Mother's Name (First, Middle, Margaret	Maiden Surname) Anna Sch	rung					
Mary 2 should Ith and M 27 is man		19a. Informant's Name/Relationship (Type, Print) Robert E. Stokes / Son	19b. Mailing Address (Street and N 29401 National I	lumber or Rural Boute Number Pike, NE, Fli	or, City or Town, State, Zio ( ntstone, MD	21530					
Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or other		1 X Rurial 2 Cremation 3 Removal from State Ceme	e of Disposition (Name of etery, crematory or other place) et Cem @ Rocky (	Date Gap 05/16/201	20c. Location - City or To 2 Flintston						
Baltimo permit. Page 1 Department of Important: If i any injury or		21. Si nature of Funeral Service Ucensee		Facility Alams Fam Street, Cumbe							
		23a. Part 1. Enter the disease, of complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, suc	ch as cardiac or respiratory ar	rest,	Approximate Interval Between					
Physician Medica		Immediate Cause (Final disease or condition resulting in death)  a. ATTRIBECTION CARLY FOR THE DISENSE.  Due to (or as a consequence of):									
Examine		HUDER POWSIG				Yrli					
ed sit	miner		w. otj:								
fbU ate be executed physician and the burial-transit	al Examine	that initiated events c. Due to (or as a consequence problem).	ce of):								
/bU cate be physic the bu	edical	d									
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aw req	plet			24a. Was		osy findings available mpletion of cause of					
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al or Attending Practice after death. I Director: After the din by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes		treet and Number or Rural	Pauta Alumbar					
UNI ital or uns after ral Dire		building, etc. (Specify)		City or Tow	n, State)						
the Hosp hin 24 hou the Fune.	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge   2  Medical Examiner: On the basis of examination and   3  Certifying Nurse Practioner: To the best of my knowledge   2  Medical Examiner: To the best of my knowledge   3  Certifying Nurse Practioner: To the best of my knowledge   3  Certifying Nurse Practioner: To the best of my knowledge   3  Certifying Physician: To the best of my knowledge   3  Certifying Physician: To the best of my knowledge   3  Certifying Physician: To the best of my knowledge   3  Certifying Physician: To the basis of examination and   3  Certifying Physician: To the basis of examination and   3  Certifying Physician: To the basis of examination and   3  Certifying Physician: To the basis of examination and   3  Certifying Physician: To the basis of examination and   4  Certifying Physician: To the basis of examination and   5  Certifying Physician: T	d/or investigation, in my opinion, dea	ath occurred at the time, date a	nd place, and due to the cau	ise(s) and manner stated					
3+		29b. Signature and title of certifier	29c. License numb	per	29d. Date signed (Month, E May 14, 201						
MLS		30. Name and address of person who completed cause of death (Item 23a Gregg C. Donaldson, M.D., 912		mberland. MD	21502						
Sta Regist		31 Date filed (Month Day Year)	parle								

			a, 19b, r FD, Alle State Registrar					d / Depa		nt of H	lealth a			/giene	200	ble.		71,36
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	Physicia Medic	al	Edna Virg										Month 05	05 <sup>Da</sup>	y	Year 2012	6:	40 PM
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	Funeral Director		5. Social Security N 220-38-00	umber	6. Sex	7. Ac		ast birthday) Yrs.	1		If Under 24	1 Hrs. 8. Min.	Date of Bi	rth av, Year)			ace (Sta	te or Foreign
	3		Usual Residence of	Decedent							<u> </u>		Januar	y 20, 1.	740			
	aryland a-f show fied at	ector	10a. State  Maryland	10b. County Alle	gany			y, Town or Lo ostburg	cation							10		e City Limits Yes 2 X No
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036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by Fune	11. Marital Status  1  Never Marr  3  Widowed		ied 1 [	Armed Forces?			Vas Deced f Yes, spec	21532- Was Decedent of Hispanic Origin? (Specify Yes or Nof Yes, specify Cuban, Mexican, Puerto Rican, etc.)						3		
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21215-0036	ithin 7; lene. r than	Com	Elementary/Sec			llege (1-4 or	5+)	life. Do	O NOT use	retired)	uning most o	Working		hon	nemak	er		
rland 2		losh		. Father's Name (First, Middle, Last)  Murrell McKenzie  18. Mother's Name (F  Edna McKen								e (First, Middle, Maiden Surname)						
Baltimore, Maryland	1 and 2 shoulk of Health and I item 27 is me other trauma		19a. Informant's Na Walter Le	wis- Shr				19b. Mailir			ive, N	or Rural Ro Frostb			Town, Sta	ate, Zip Co	ode) 215	32-
imore	permit. Page 1 a Department of H Important: If itel any injury or oth		20a. Method of Disp 1 Burial 2 4 Donation	☐ Cremation		al from State		Place of Dispo emetery, cren rostburg I	sition (Nan	ne of ther plac	e)	Date May 0	7, 2012	_	ocation - C tburg		vn, State <b>trylan</b> e	
Balt	permit Depart Import any inj		21. Signature of Fu	neral Service L	Cepede	er I	1				s of Facility I Home,	57 Fro	st Ave.	, Frost	burg, N	MD 21	.532	
	Physician/ Medical Examiner	iner	23a. P. 1. Enter thook, or heal Immediate Cause (disease or condition resulting in death)  Sequentially list continuous. Enter Under Cause. Enter Under Cause.	rt failure. List o Final n	a. — b. —	Due to (or as	e. Ponsequ	ration and the series of the s	M/X	e of dying	- A		M CY	- 1	seo			mate Between nd Death
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. Box 68760	for the Hospital or Attending Physician: The law requires that the death certificate E within 24 hours after death.  For the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the the total page.		IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 € 9 ☐ Unknown	months? No	1 4	ves, outcome Live Birth Pregnant a Unknown	2 Feta	I death 3	Ectopic p		y		23d. Date of delivery  Month Day Year			Year		
s, P.O.	ires that the signed by do be deta	d by Pi	Part II. Other signif	icant conditio	ns contributi	ng to death t	out not resi	ulting in the u	nderlying o	cause giv	en in Part I.		23e. Did t					of death?
Division of Vital Records,	ne law requ e has beer age 2 shou	omplete		epper	lide	mia	, ,					_	24a. Was auto	psy ormed?	pri de	ior to com eath?	pletion	gs available of cause of
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on o	ending Feath.	Certificate: To Be	27. Manner of Death  1 X Natural 2 Accident	5 Pending _ Investig	ation	a. Date of inju (Month, Da	iry y, Year)	28b. Time of injury	M 2	8c. Injury work: 1 🔲	at ′ Yes 2 ☐ Ne	- 1	Describe h	now injury	occurred	I		
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completed filled in by the fu	al Certi	3 ∐ Suicide 4 ∏ Homicide	6 ☐ Could r determi		. Place of Injubulged	ury - At ho c. <i>(Specify)</i>	me, farm, stre	et, factory	, office		28f.	Location (\$ City or Tov			or Rural F	Route Nu	mber,
	the Hosp nin 24 hou the Funer	Medical	(Check 2	Certifying Medical Ex Certifying	aminer: On	the basis of e	examination	and/or invest	igation, in r	my opinio	n, death occu	rred at the	time, date a	and place.	and due t	o the caus	e(s) and	manner stated.
	To with		29b. Signature and t	title of certifier	v	MD			29c.	License	number 6	50		29d. Dat	e signed (	Month, Da	ay, Year)	
	nes		30. Name and addre	ess of person w	no complete	ed cause of d	leath (Item	23a) (Type, P	rint)	TA	so Si	in the	2011	Coon	u Or on	lower	d N	1D
	Stat Registra	- I	31. Date filed (Month	0°7 201	2 h	32. Registra	ar's Signati	barke	1				7.04	-001	V V	, , , ,	~ 1 \	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Samuel Kenneth Snyder Sr. 2059M Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death 4b. City, Town, or Location of Death <u>Meritus Medical Center</u> Washington <u>Hagerstown</u> 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) Nov.29,1937 Hours 194-28-9336 Director 1 🕅 M 2 □ F 74 Maryland Yrs Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location Director 10d. Inside City Limits Md. Washington Hagerstown 1 XYes 2 No 10e. Street and Number 10f. Zip Code ò items 23a or ner must be n 10g. Citizen of What Country? 21740 Funeral 1034 Salem Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify "natural", White Specify. Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Driver Trucking Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ot ဂ္ Hubert Snyder Helen McSherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Scott L. Snyder (Son) 1034 Salem Ave. Hagerstown, Md. 21740 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Boonsboro Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Page 1 a 1 Name Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Boonsboro, Md. Signature of Funeral Service License 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 the use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Emphyzema Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 Yes Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: ျာ 1 Inpatient 2 XER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory. office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signate 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northern Aul 580C State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month May Bruce Α. Stayman 201<sup>rea</sup> 12 9:32 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 203-24-7842 Director 1 🔀 M 2 🗆 F 80 June 6, 1931 PA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13110 Wilton Oaks Drive 20906 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 X Yes 2 ☐ No 1 Never Married 2 Married Black, White, etc Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: "natural", If Yes, Give 3 Divorced Year or Dates. Korea 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Howard Stayman Mary Hilt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Heatth Important: If item 27 any injury or other th once. Diana M. Stayman/Wife 13110 Wilton Oaks Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) May 21, 2012 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercises) Examine Due to (or as a consequence of): for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Day Year been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Nuknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2: this certificate 1 ☐ Yes 2 ☐ No Yes 2 

✓ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🔀 No ဂ 1 ☐ Inpatient 2 ☐ ★ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No ☐ Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State Registrar

DHMH 17 Rev 06-2011

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MAY 16 2012

Steven

31. Date filed (Month, Day, Year)

5

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gin

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D24348

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

05. 12.2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene = State Registrar AMEND#23a(a)perMD,5/24/12; BMN,MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 13, Physician/ Edward Burgess Sonnemann May 1:15 аМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min 216-74-0206 Director 1 XM 2 - F Yrs 72 Usual Residence of Decedent Jan. 9, 1940 Washington, DC or 28a-f show notified at 10a. State should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits MD 1 Yes 2 K No Montgomery Silver Spring 10e. Street and Number ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 10311 Brookmoor Drive 20901 "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur. jury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Never Worked N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Lamonte Fredrick Sonnemann Lila Douglas Burgess 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Bennett/Niece 10311 Brookmoor Drive, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of May 17 2012 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, MD . Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 PUU University Bivd. W., Sil 23a. Part 1 Approximate shock, or heart failure. List only one cause on each line Empy ema Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Emphysema Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Down's Syndrome that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death 5 Other (specify) Month Year a Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 X No 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 XNo ၉ 1 Yes 1 K Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury X Natural 5 Pending Investigation filled in by the Accident Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 S.C. Gupta, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral		5. Social Security Number	6. Sex 1 <b>X</b> N		Age (In yrs	last birthday)			er 24 Hrs. Min.	8. Date of Birt	th v Voor		9. Birthp Count	lace (State or Fore	ign
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iled vill Hyg	Be	17. Father's Name (First, Midd	ile, Last)					18. Mo	ther's Nam	e (First, Middle,	Maiden S	Sumame)			
l be f fenta rrked tic e	은	Louis She	arin					L	inni	e Jeff	ers	on			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relati	onship (Type, I	Print)		19b. Mailii	ng Addre	ss (Street and Num					ate, Zip O	iode)	
d 2 s alth alth 27 i		James M. Sh	earin	/Son		422	Og1	ethorpe	St,I	W,Wasl	hing	jton	,DC	20011	
1 an of He Fiten		20a. Method of Disposition			20b. I	Place of Dispo	sition (N	ame of		Date	20c. Lc	cation -	City or <b>To</b>	wn, State	
Page nent int: II		1 ☐ Burial 2 ☐ Cremate 4 🔀 Donation 5 ☐ Oth		noval from Sta	te Hot	ward d	MIV	ersity lool	5/3	/12	Wa	shir	nato	n,DC	
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Depar Depar Impor any ir		Kolis	Cl.	And	66	- 3	821	14th St	tree	t, NW, Wa	ashi	Lngt	on,	OC 200	11
		23a. Part 1. Enter the disease shock, or heart failure. L	e, or complicat	ions that caus	ed the dea	th. Do not ent	er the m	ode of dying, such a	as cardiac	or respiratory am	rest,			Approximate	
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ifficating phase the	Physician/Medi	IF FEMALE:													
endir r use	an/	23b. Was decedent pregnant		If yes, outcom			Ectopi	c pregnancy					e of delive		
death	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 Pregnan 9 Unknow	t at time of		Other					Mon	ith	Day Year	
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aw re as be 2 sh	lg	CO	ugesty	re H	eart	Jan	lur.	۷		24a. Was autop		pr	rior to cor	sy findings availat npletion of cause o	ile of
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ertific ctor,	Be (	25. Was case referred to med examiner?						26. Place of De	eath (Chec	k only one)					
hysic nis ce I direa	ပ	1 ☐ Yes 2 ☑ No	Hosp	oital: 1 🗌 Inpa	atient 2 🗆	ER/Outpatie	nt 3 🗆	DOA Other: 4	Nursing Ho	ome 5 Resid	ence 6	Other	(Specify)		
ng Pl fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pe		28a. Date of ir (Month, L	njury Day, Year)	28b. Time of injury		28c. Injury at work?		28d. Describe h	ow injury	occurre	d		
eath. or: Ai	fica	2 Accident Inv	estigation				М	1 ☐ Yes 2	□ No						
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the													_		
Hosp 14 ho Fune ted fi	Medical							at the time, date an n my opinion, death							tated.
the thin 2 the I	Me			actioner: To the	ne best of m	y knowledge,		curred at the time, da							_
ڄ ڇ ڇ		29b. Signature and title of con		2/4				9c. License number 00636				-	Month, E		
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		30. Name and address of pers						-E #208;	Lkra++	-crillo	MD	2020	23		
-04-		Ajit Kurup, 31. Date filed (Month, Day, Yea						-£ #2U0;	ııyatl	SATTIE,	עוייו	2010	, ,		
Stat Registra		MAY 1 6		2. negls	ar a Oigi	ture for	The same								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May George Henry Snellings, III. 73 2012 19:03P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number **Funeral** . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours 79 Yrs. (Month, Day, Year) 03/28/1933 Director 225-34-5215 Richmond Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location be notified at **Funeral Director** 10d. Inside City Limits 28a-f MD 1 Yes 2 No St. Marv's Charlotte Hall 6 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ms 23a (must be 30564 Mohawk Court 20622 items ( 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. by Black, White, etc 6 1 Never Married 2 X Married and 2 should be filed within 72 hours after altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give "natural" Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the n and Mental Hygien 7 is marked other tl Management Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anita Agnes Lel George Henry Snellings, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Mary Femiano Snellings / Wife 30564 Mohawk Court, Charlotte Hall, MD 20622 20a. Method of Disposition Department of H Important: If ite any injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State st. Mary's Catholic Church Cemetery 4 Donation 5 Other (Specify) 05/25/2012 Bryantown, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols, F.H., P.A. ##M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner OBSTRUCTIVE PULMONARY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Pregnant at time of death Month Day Year ate has been signed by the a page 2 should be detached to 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate I performed completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ၉ 1 Tyes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending Natural 1 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number determined within 24 hours a To the Funeral L Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 9c. License number wal 30. Name and address of person who completed caus death (Item 23a) (Type, Print)
ST. MARYS LOSPITAL LEONARDTOWN MARYLAND ATRICIA GURM, MD 31. Date filed (Month, Day, Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

			Please Type or Print in Black			
			1 - State of Maryland / Dep	partment of Health and ertificate of Death		
	Physicia Medi		1. Decedent's Name (First, Middle, Last) James Barry Smith		2. Date of Death	Day 2012 <sup>Year</sup> 3. Time of Death 10:40 A M
	Examir		4a. Facility Name (if not institution, give street and number) 12041 Crouse Mill Road	4b City Town or Location of Dea	ith	4c. County of Death Caroline
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year   If Under 24 Hr   Months   Days   Hours   Min		9. Birthplace (State or Foreign Rauntry) Maryland
	/aryland 8a-f show tified at	Director	Usual Residence of Decedent  10a. State	ocation ge1y		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the N s 23a or 2 ust be no	Funeral Di	10e. Street and Number 12041 Crouse Mill Road	10f. Zip Code 21660	109	Citizen of What Country?
9036	e filed within 72 hours after death with the Maryland ttal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	within 72 hor giene. e <b>r than "nat</b> , <b>the Medi</b> es	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary Scort and 12)  College (1-4 or 5+)  Tri	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) uck Driver	orking 16t	o. Kind of Business Industry  Grain
land	l be filed lental Hy rked oth lic event	To Be	17. Father's Name (First, Middle, Last) Lester James Smith	18. Mother's Na Eloise	ame (First, Middle, Maid	en Symame) Ellwanger
, Mary	1 and 2 should be file of Health and Mental F item 27 is marked of other traumatic ever		19a. Informant's Name/Relationship (Type, Print) Florence Dobson-Gonzales / caretaker 1204	ling Address (Street and Number or R 1 Crouse Mill Rd., Ri	ural Route Number City dgeLy, MD 216	or Town, State, Zip Code)
timore	permit. Page 1 ar Department of He Important: If iten any Injury or oth			ematory or other place)		. Location - City or Town, State
Bal	Depar Impor any In			22. Name and Address of Facility Moore Funeral Home, P.	.A., 12S. Seco	ondSt., Denton, MD21629
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions,		eme	Approximate Interval Between Onset and Death
90	te be executed nysician and ne burial-transit	dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):			
). Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P.O.	equires that een signed k nould be det	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part 1.		o use contribute to the cause of death?
Division of Vital Records,	rsician: The law r s certificate has b lirector, page 2 sk	Completed	tor DIN		24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2 No
Vital	lysician is certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2  ER/Outpatie	26. Place of Death (Che	eck only one)  Home 5 Residence	6 Other Specify
on of	ttending Physician: 1 death. stor: After this certifice / the funeral director, p	Certificate:	27. Manney of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident Investigation		28d. Describe how in	
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Sta	
	the Hosp hin 24 hou the Funei npleted fil	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death best only one)  1 Medical Examiner: On the basis of examination and/or investigation of my knowledge, death only one)	stigation, in my opinion, death occurred	at the time, date and pla	ice, and due to the cause(s) and manner stated
	o viii		29b. Signature and title of certifier	29c. License number 325	2 2	Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Melinda Butter 3683 CM	Print) Print Rd	Presta	- MD 21655
	Stat Registra	e ar	31. Date filed (Month, Dev. Year) 32. Registrar's Signature			

DHMH 17 Rev 7/2009

AS1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 5-35 yde Sealer Medical 4a. Facility Name lif not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritace Hanbour Health & Rehal, Cenix Armapolis the Arundel If Under 1 Year / If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Funeral Director 061-64-8463 1 X M 2 🗆 F 101 08/08/1910 Panama show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified 1 Yes 2 X No MD Calvert Chesapeake Beach 10e. Street and Numbe 10g. Citizen of What Country? ms 23a or must be r Funeral 3555 Ponds Wood Drive 20732 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iten I Examiner r 11. Marital Status Black, White, etc. by 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed | Specify: "natural", 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation

\*Give kind of work done during most of working other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) U.S. Government clerk / typist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Prince Alfred Sealey Beatrice Parris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Olive M. Sealey, wife 3555 Ponds Wood Dr., Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 5/20/2012 Alexandria, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Liver 22. Name and Address of Facility Rausch Funeral Home, P.A. ubarl 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or compli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart falure. List only one cause on each line.
Immediate Cause (Final Interval Between Onset and Death Atheresclerotic Cerebral Vascula Biscare Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 2 No within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? Certificate: Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R104-317 10/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aricetion 6934 Boulevard SteB alen Brinic MD2106 DIANA NO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #25, per me, g928 6-25-12 sm

State of Maryland / Department of Health and Mental Hygiene
AMEND 28A-C, PER ME G929 7/5/12 TRT

Certificate of Death

Reg. No. 20 | 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ORINE 0937 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL MONTGOMELY WTS HING TON TAKOMA COV 09 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. NOVEMBER 7.1938 MARYEAND 214-38-9306 73 Director Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MARYLAND CHARLES INDIAN HEAD 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country er than "natural", or items 23a of the Medical Examiner must be Funeral UNITED STATES 5385 NELSON POINT ROAD 20640 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) EXPLOSIVE OPERATOR FEDERAL GOVERNMENT 12TH GRADE Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of er traumatic ever ၉ DANIEL WEBSTER LAWSON Page 1 and 2 should be nent of Health and Ments MAMIE VIOLA RICHARDSON LAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMUEL SAVOY / HUSBAND 5385 NELSON POINT ROAD, INDIAN HEAD, MARYLAND 20640 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State OAK GROVE CHURCH CEMETERY MAY 19, 2012 NANJEMOY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Livenses THORNTON FUNERAL HOME, P.A LYDIA C. THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ DIABETES disease or condition resulting in death) Medical Due to (or as a consequence of) <sup>€</sup>Examiner ADDITIL DILIECTION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of CERTIFICATION APPROVED BY MEDICAL EXAMINER that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? be detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 2 🗆 No 9 Unknown Ö been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🙇 Natural injury 5 Pending Division 1 Tes Accident Suicide Investigation 0937 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge; 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) sof person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Ante HEIK H Helou 600 31. Date filed (Mont gistrar's Signatur State 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Evelyn Stinson May Month Day 20 42 Physician/ 15 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Manor Care Nursing Largo Largo . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min 1 🕅 M 2 🗆 F Months Hours oct 29 254-58-0434 193<u>7</u> 74 Director Usual Residence of Decedent 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director Forestville, Md Prince Georges 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20747 1305 Alberta Dr Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Was Decedon.
Armed Forces?

1 Yes 24 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry th and | ental Hygiene.
27 is marked other than traum tic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Key Maker PVT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dorothy Brown Murphy Ralph Murphy permit. Page 1 and 2 shoult i e Department of Health and i ent Important: If item 27 is marke any injury or other traum: tic e once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Alberta Dr Forestville Md 20747 Joseph Stinson 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition vet. Cem. May 1 M Burial 2 Cremation 3 Removal from State Md. 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham 2012 22. Name and Address of Facility McLaughlin Funeral Home 21. Signat of Funeral Service cc0257 2518 PA Ave SE Washington DC 20020 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriolosclerosis Heart Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Dan to for as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Probably 4 Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? Decubitus Ulcer 24a. Was an autopsy performed? 1 Yes 2 No 1 🔀 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signature and title occertifier

31. Date filed (Month, Day,

1160 Varnum St,

7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NE # 217

32. Regis ar's Signature

29c. License number

Washington DC 20017

D0020624

Lester Miles

29d. Date signed (Month, Day, Year)

May 16, 2012

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month Physician/ Mossing Troen 10:15 Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 912 Hollywood Avenue If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Days Hours (Month, Day, Year) 227-74-5414 Director 1 X M 2 ∏ F 61 Yrs July 21, 1950 Virginia Usual Residence of Decedent r than "neturel", or items 23e or 28a-f show the Medical Examiner must be nutified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 🏝 No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20904 USA 912 Hollywood Avenue death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 Never Married 2 Married ğ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 To No Specify: 3 🔀 Widowed 4 □ Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 4 Consultant Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H Marilyn Mossing Luther Troen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pege 1 and 2 sh iment of Health a tant: If Item 27 Is 1237 Glyndon Avenue, Baltimore, MD 21223 Nicole T. St. Hilaire/Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition May 16, \$ = P ematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny Injury or Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ Cardiac Arrest ease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Ventricular Tachycardia Sequentially list conditions, if any, leading to immediate cause. Line: Underlying Cause (Disease or injury Due to (or as a consequence of) o burill-transit To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burna-transit 3 yrs Cardiomyopathy that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Old Heart Attack 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Nother (Specify) 1 ☐ Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

7500 Hanover Parkway, Greenbelt, MD 20770

5-15-2012

utrulle

Sridhar Chatrathi, MD

MAY 16 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 19, **Tippett** 5:55 A M **Elaine** Sandra May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 45200 Clarkes Landing Road Hollywood St. Mary's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 214-68-7586 Director 1 □ M 2 🎛 F 57 Yrs 05/06/1955 Washington, DC Usual Residence of Decede 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 Tes 2 No Hollywood St. Mary's Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be n Funeral 20636 USA 45200 Clarkes Landing Road items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 K Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Director of Operations 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of Section 1 permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic events. ဂ္ဂ Marie O'Dean Banks Ralph I. Raley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45200 Clarkes Landing Road Hollywood, MD Joseph Albert Tippett/Husband Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, Charles Memorial Grds 05/23/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility - Gardiner Funeral Home, 41590 Fenwick Street Leonardtown, MD 20 Signature of Funeral Service P.A. heliae 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ymphoma disease or condition Medical resulting in death) years nsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-transit Due to (or as a consequence of): ding physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 98 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy this certificate 2 No 1 Yes Yes if or Attending Physician: after death.

Director: After this certifications director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No \_\_ Accident Investigation 6 Could not be the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20619 Shah, M.D. 23415 Three Notch Road Store 2050 CAlifornia, MD Minal M.

000681

29d. Date signed (Month, Day, Year)

5-21-12

State Registrar 29b. Signature and title of certifie

mb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 4c&10b per FH G936 2/12/13 dk
State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month THURMAN 1:05 A M RUDELL TYLER May 6. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 720 West Watersville Rd. Mount Airy Frederick Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 217-22-1749 **Director** 88 1X M 2 | F June 12,1923 Maryland Usual Residence of Decedent 10b. County Howard 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland -Frederick Mount Airy 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Completed by Funeral 720 West Watersville Rd. 21771 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, than "natural", or ite Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black 3 Widowed 4 Divorced Specify: Year or Dates. 1944-46 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Business proprietor Trucking Company 27 is marked other traumatic event, th Be 17. Father's Name (First, Middle, Last) utn and Mental H 18. Mother's Name (First, Middle, Maiden Sumame) 2 George Washington Tyler 01ia Mae Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Minnie J. Tyler / Wife 720 West Watersville, Rd. / Mount Airy, MD 21771 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o ō 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Resthaven Memorial 05/12/2012 Frederick, Maryland 21. Signatu of Funeral Service Li 22. Name and Address of Facility Stauffer Funeral Homes, P.A. E. Ridgeville Blvd./Mount Airy, MD 23a. Part 1 whiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoots or heart failure. List only one cause on each line. Interval Between set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** 1/2ans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No Month Day signed by the at the detached for 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{P} \) Residence \( 6 \text{ \text{Other}} \) Other (Specify) ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh, MD / 26033 Ridge Rd., / Damascus, Maryland 20872 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY Registrar 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav 10:00 PM 2012 Jerry C. Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Prince George's Lanham 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 057-42-7959 M 2 D F Director 60 8/31/1951 NC show 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f DC Washington 1x Yes 2 No 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 'n 27 is marked other than "natural", or items 23a of traumatic event, the Medical Examiner must be Completed by Funeral 1720 Corcoran Street 20002 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2**X** No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes No Specify Specify: Black 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Company Dispatcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental | marked c ျှ Geneva Thompson Ralph Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Thompson /Brother 18906 Port Haven Pl.Germantown, MD 20876 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any injury or ot 5/17/2012 Goldsboro, NC 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Goldsboro Cremation 21. Signature of Funeral Service License 22. Name and Address of Facility Briscoe-Tonic Funeral Old Washington Rd. Waldorf, MD 20601 2294 23a, Parl 1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure List only Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last and attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death been signed by the a should be detached Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Tachycardia 1 Yes 2 No 3 Probably 4 Unknown Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No espiratory 24a. Was an autopsy this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending Accident Investigation filled in by the Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 2ga. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number cause of death (Item 23a) (Type, Print) Laskam, MD. 20706 mI). 3118 Good hall Rd. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ VanMeter Leslie Dale May 012 7:02 Р Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 13380 Heather Street, SW Cumberland Allegany 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/01/1951 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Hours Min Months 215-56-9092 61 Maryland Director Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 Yes 2 No Cumberland MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 23aFuneral 21502 13380 Heather Street, SW 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Yes 2 ☐ No If Yes, Give Year or Dates. 1 ☐ Never Married 2 🏋 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Completed White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Buyer Trucking 12 should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VanMeter Bohrer မ Cranston James Georgia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 13380 Heather Street, SW, Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau B. Jean VanMeter / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Cumberland Crematory 05/08/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) agricture of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ADENOCAREINO MA LU MG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying and I-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialsigned by the attending physician Physician/Medical requires that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No ō Pregnant at time of death Month Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 st autonsy 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27, Manner of Death 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examining and a large strategy and the time, date and place, and due to the cause(s) and manner as stated.

 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0014865 May 8, 2012

State Registrar 200 Glenn Street, Cumberland, MD

Sure

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robustiano J. Barrera, Jr, M.D., 200

ourbano

0 8 2012

31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year CHARLES EDWARD WEAKLEY, III 05 2012 Medical 9:10 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nursing Home Frostburg Allegany Social Security Number 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) 08/04/1923 7. Age (In vrs. last birthday **Funeral** Min. 1 X M 2 □ F **Director** 234-32-8880 88 West Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13203 Pershing Street, Rt. 9 within 72 hours after death with 21502 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WWII Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Radio Technician State of Maryland 5+ Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heath and 2 should be Department of Heath and Menta Important. If item 27 is marked, any injury or other traumost. Charles Edward Weakley, Jr. ည (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Weakley, IV / Son 13203 Pershing St., Rt. 9, Cumberland, MD 21502 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) M.S.V.C. Rocky Gap 05/09/2012 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Upchurch Funeral 202 Greene St., Cumberland, MD 21. Signature of Funeral Service Lig HOme. 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Sepsis Physician/ disease or condition resulting in death) Syndrome imo Medical r as a consequence of Examiner Bacterial endocarditis mo Sequentially list conditions cause. (Disease or linjury Due to for as a consequence of Exami and -transit that initiated events resulting in death) Last Due to (or as a consequence of): as the burialattending physician Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year by the 9 Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes ျပ 4X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending death. Investigation Accident 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Tpleted 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0005532 11+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCKSHIN Walsh Rd Bishon 925 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ May 04, 2012 ear 1955M Larry Allen Warnick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Health Nursing and Rehabilitation Cent Allegany Cumberland 8. Date of Birth (Month, Day, Year) August 15, 1943 Birthplace (State or Foreign Country)
 Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Days Hours Director 218-74-7534 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f showons any injury or other traumatic event, the Medical Examinations 200. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ✓ Yes 2 ☐ No Cumberland Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 730 Furnace Street 21502 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Wilhelmina Lee Allen Warnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10514 Mt. Savage Road, Cumberland, Maryland, 21502 Gregory Warnick - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date May 07, cemetery, crematory or other place)
Laurel Hill Cemetery 1 Burial 2 Cremation 3 Removal from State Moscow Mills, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Lonaconing, MD 21539 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPI Valion disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No this certificate To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred Certificate: 1- Natural work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of gertifi 29d. Date signed (Month, Day, Year) 29c. License numbe D0033280

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Kent Avenue Suite #101 Cumber and Mayland 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4079 Old Muddy Creek Rd. Edgewater Anne Arundel 8. Date of Birth (Month, Day, Jan 22 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1940 217-38-2640 Director 1 □ M 2**X** F Maryland 72 Yrs. or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Edgewater Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4079 Old Muddy Creek Rd. 21037 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education 12th 6yrs Educator marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ Unobtainable Vashti Thomas 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12618 Pavillion Ct. Upper Marlboro, Md. 1 and 2 sof Health item 27 Chkeada Cole(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit, Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State Zion UM Church 5-18-12 4 ☐ Donation 5 ☐ Other (Specify) Lothian, Md. 21. Signature of Funeral Service Licenses Windame a Regense of Facility Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart fallure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ CONGESTIVE HEART FAILURE Medical Examiner CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 ☐ Yes 2 🛣 No 9 ☐ Unknown Month Year ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INFARCTION MYOCARDIAL 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe RENAL TAILURG Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined. Medical 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-15-12 D 14774 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D

Registrar

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2012 Mabel Williams 10:10A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1810 Grenwich Woods Dr. Montgomery Silver Spring Apt 13 Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 248-14-9936 Director 1 □ M 2**X**J F S. Carolina 98 Mar 11 1914 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 ☐ Yes 2X No 5 10g. Citizen of What Country? 23a Funeral 1810 Grenwich Woods Dr. Apt 20903 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter or Black, White, etc. Completed by Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

The 27 is marked other than "natural", or with filem 27 is marked other than "natural", to ury or other traumatic event, the Medical Examini 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black 3 ¥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Metropolitan Elementary/Secondary (0-12) 12th College (1-4 or 5+)
2yrs Medical Stenograher Hospital Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Adolphis Young Maliah Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mamie R. McCullough(Daughter) 5813 Lawton Ct. Lanham, Md, Department of Health Important: If item 27 any injury or other to once. 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Maline of 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 5-17-12 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses W Marne a Recese of Facility Sons Mortuary, P.A. Lavy 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INSEASE GRONARY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** INFARCTION MYOCARBIAL Sequentially list conditions Examiner if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 the as t IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year Yes 9 Unknown by 1 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of ate has bage 2 s autopsy death? performe Yes 2 Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer X Natural 5 Pendina Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) IMO D71264 12012

State Registrar

DHMH 17 Rev 06-2011

UZO UNEGBU, MD 7350 VAN DUSEN RD SUITEZZO LAMREY MO ZUTOT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 18ay 2ÖÏ2 3:30 Рм Donald Eugene Walker Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Caroline 211 Old Town Road Goldsboro If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 11/10/1942 Director 69 Maryland 217-42-5771 Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Caroline Goldsboro Mary1and 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 25822 Goldsboro Road 21636 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12 College (1-4 or 5+) Self employed Dog groomer traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Lee Walker Mildred Hannah Whitby of Health and Melfitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ridgely, Maryland 21660 H. F. Winters, Jr./POA 11773 Central Avenue Ext. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 and Department of Information of Inf ē 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 5/24/2012 Easton, Maryland Woodlawn Cemeterv 21. Sanatur f Funeral Service Licens 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, Maryland 21629 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER UNKNOWN METASTATIC MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has l performed this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ပ္ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA n 24 hours after death.

e Funeral Director: After tholeted filled in by the funeral Manger of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signatule

Dr. David H. Smith

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

8221 Teal Drive #301

D3988

Easton, Maryland

29d. Date signed (Month, Day, Year) 21 51

21601

12012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 15, Physician/ 2012 12:30 AM James Dawson Willoughby, Sr. . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Caroline 538 Liberty Road Federalsburg 6. Sex 1 X M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Days 12/24/1952 59 Director 215-58-5782 Usual Residence of Decedent show or 28a-f shown notified at 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location Director 1 Yes 2 X No Federalsburg Marvland Caroline 10e Street and Number 10f. Zip Code 6 10g. Citizen of What Country? ms 23a or must be n Funeral 21632 USA 538 Liberty Road items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc. ō ş 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 X Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. ed other than " event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) Janitoria1 Municipa1 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Joyce Long Frank Dawson Willoughby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henderson, Marvland 21640 M. Diane Bartz/sister 17489 Melville Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 5/22/2012 4 ☐ Donation 5 ☐ Other (Specify) Federalsburg, Maryland Concord Cemetery Signature of Funeral Service 22. Name and Address of Facility Moore Funeral Home, P.A. South 2nd Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer LUNG disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Į. Pregnant at time of death Month Dav Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medica completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rreston 3683 Chapt

State Registrar 31. Date filed (Month, Day, Year)

Melinda Bu

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>012</u> Physician/ Month 8:00PM Yvonne Hallowell Wright May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
Caroline 4940 Federalsburg Highway Federalsburg 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 214-34-5973 75 1937 Director Mar. Delaware Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City Town or Location 10d. Inside City Limits Director Caroline Federalsburg MD 1 Xyes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 21632 301 Porter Court United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify SpecifyWhite Completed 3 ♥Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant should be filed with n and Mental Hygien is marked other th Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Bowers Harry Thomas Hallowell traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 102, Denton, MD 21629 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Beverly Adams/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State metery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05/15/12 Federalsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Hill Crest Cem. Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ +0 disease or condition resulting in death) als Medical Due to (or as Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and trar Due to (or as a consequence of): resulting in death) Last burial Physician/Medical The law requires that the death certificate be Box 68760 phys the L IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No ō Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera Natural 2 28d. Describe how injury occurred work? 5 Pending injury 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year May 9, 2012 Day Isidora C. Ware 7:50 а м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1390 Emmanuel Church Road Calvert Huntingtown 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Country) Yrs June 30, 1909 **Director** 102 578-10-9008 Usual Residence of Decedent 28a-f shov 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No MD Calvert Huntingtown 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 3930 Capital Hill Lane 20639 items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. o à 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: "natural", Completed 3 ₩ Widowed 4 □ Divorced Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4-or 5+) Elementary/Seconday (0-12) Owner Poultry Market and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental fitem 27 is marked 9 Unknown Margie Carter 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 2618 Lady Anne's Way Huntingtown, MD 20639 Patricia Kinzer - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Harmony Memorial Park | May 16, 2012 | Largo, MD 4 Donation 5 Other (Specify) Sewell Funeral Home, P.A. . Signature of Funeral Service Licenses 22. Name and Address of Facility Dladep 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ heimer disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? à Records, or Attending Physician: The law requires VASCU Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in musclinia Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practiciner: To the best of my knowledge. Shall continue at the time, date and place and due to the cause(s) and manner stated. (Check 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) Merrimac oble 238 mON 32. Registrar's Signature State Registrar

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	Funeral Director		5. Social Security Number 231-54-3762	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs. las		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bird (Month, Da	y, Year)		Count	• •
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Baltimore,	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition  1X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (	3 ☐ Removal from	State Cer	metery, crem	sition (Name of latory or other pla ST CHURCH (	ce) CEM• (	_	ate 3/2012		_ocation - 0	-	
Ball	permit Depart Impor any in		21. Signature of Funeral Service	Licensee			Name and Addre		. 070	4 MARY CASTER			)3	
		23a. Part 1. Enter t disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  SEPSIS  Due to (or as a consequence of):												Approximate Interval Between
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Box 6	Hospital or Attending Physician: The law requires that the death certificate be executed 424 hours after death. Fureral Director, After this certificate has been signed by the attending physician and telly filled in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director.	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live E	ant at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year		
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	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check 2 L Medical I	g Physician: To the be Examiner: On the basi g Nurse Practitioner:	s of examination a	and/or investi	gation, in my opini	on, death oc	curred at t	he time, date ar	nd place	e, and due to	o the cau:	se(s) and manner stated.
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	m		30. Name and address of person	who completed cause	of death (Item 2	3a) (Type, Pr	int)				4D 0	0011		
	Çta:		DR. JAYANTI LA					v RD;	BETH	ESDA, N	MD 2	U814		
	Stat Registra	e	31. Date filed (Month, Pay Year)	2012	gistrar's Signatu	. pa	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 9. 2012 Granvel S. Walker 6:12 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Hours 234 60 1364 Director 1 XXM 2 □ F 72 March 22, 1940 West Virginia ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Prince George's **Clinton** Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral 6417 Kaine Drive 20735 United States and Mental Hygiene.

is marked other than "natural", or items:
aumatic event, the Medical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 1 Yes 2 1 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 1958-1962 Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygier, Important; If item 27 is marked otherwing night or other throng none. IUEC # 10 Elevator Construction Elevator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ A. Otto Walker Sadie E. Shrader 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia M. Walker (Wife) 6417 Kaine Drive, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 5/16/2012 Maryland Veterans Cometery Cheltenham MD 22. Name and Address of Facility
Les Funeral Home, Inc 6633 Old Alexandria
Ferry Road, Clinton, MD 20735 21. Signatural of Funeral Service Lice 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physiciani SMALL CELL LUNG disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). and that initiated events resulting in death) Last Due to (or as a consequence of): burialby the attending physician stached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEPSIS Completed 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 6 has performed' Yes 21 25. Was case referred to medical examiner?

1 Yes No To the Hospital or Attending Physician; funeral director, Be 26. Place of Death (Check only one) Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0064986 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Da 32. Registrar's Signature State Registrar

**ORIGINAL** 

29c, License number O.C.M.E.

29d. Date signed (Month, Day, Year)

May 27, 2012

30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perFH, G931,9/26/2012, WS
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 201 Town or Location of Death Mary Land County of Death **Examiner** Hospital 549-48-3318 If Under Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State & Country) **Funeral** Months Hours Min Director 1 □ M 2 😿 F ecember 7 28a-f show 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director ple Hills 1 Yes 2 ☐ No PINCE 10e. Street and Number or items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces:

1 X Yes 2 L

If Yes, Give

Year or Dates. Black, White, etc. þ ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No "natural", Specify: Specify: /3/ack Widowed 4 Divorced Completed Unknown 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be filed very perartment of Health and Mental Hygemortant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a. Method of Asposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other Specify) 21. signatur 22 Name and Address of any Approximate Interval Between Onset and Death ne disease, or complications that caused the death. Do not enter the mode of dying, subshock, or leart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, with unsured at the time, data and class 29b. Signature and title of certifier 29c. License number (8 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ May 24 09:00 a M Artis Irene Bess Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Hours 84 **Director** 242-38-3959 1 M 2 X F Apr 28 NC 1928 or 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits the Maryland Director Md Prince George' temple Hills 1X Yes 2 ☐ No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ŏ ms 23a or must be r Funeral 3315 26th Ave 20748 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 Î No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Government Computer Operator 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Morrison Jennie Sifford Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3315 26th Ave Temple Hills Robert Bess - Son 20748 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 1 Harmony

Harmony 1 Burial 2 Cremation 3 Removal from State Landover Md 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral 22. Name and Address of Facility McLaughlin Funeral Home <u>Pa</u> SE Ave Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending injury Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 29c. License numbe 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Jacqueline (050 - M Medical Onetta MAY 2612 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Director 214-68-3920 1 M 2 X F 56 Usual Residence of Decede 12/05/1955 Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits MD 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2802 Oakley Road <u> 21215</u> U.S.A 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give 3 Widowed 4 X Divorced Completed Year or Dates. Black traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry I Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bartender Restaurant Be Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file if Health and Mental H item 27 is marked o Eva N. McKnight and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carendy Smith / Daughter 3808 Pinkney Road, Baltimore, MD 21215 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry 06/01/2012 | Hanover, Maryland 21. Signature of Fundal Serve License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death ANOXIC BRAIN INJURY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 3 days ARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hypertension Should Completed 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? 1 Yes 2 No 1 Yes 2 X No the funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No မ Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) KULT OILLUL MO RES 000 may 24,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHLEEN OKTAVEC SINAL HOSPITAL OF BALTUMORE MDWHS 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

2

2

## amend 16a-b, per fh, g928 6-4-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland / Dep	artment of Health rtificate of Death	and Mental Hy	201	2 17465
			Registrar  1. Decedent's Name (First, Middle, Las		Tirodio or Bodir	2. Date of D		3. Time of Death
	Physicia		WILLENE BO	GGS		Month	Day Year	
ding	/Medio		4a. Facility Name (If not institution, give		4b. City, Town, or Location		4c. County of Dea	
			Johns Hopkins Bayvie	w Medical Center	Baltimore		N/A	
	Funeral		5. Social Security Number 1 6. Sec. 213 - 78 - 4311	_ 37	If Under 1 Year If Under Months Days Hours	7 24 Hrs. 8. Date of B Min. (Month, D	irth 9. Bi	rthplace (State or Foreign ountry)
	Director		·	M 2 <del>M</del> F 52 Yrs.	Indiano Bayo Modio	Feb 2	2,1960	MD
	and and		Usual Residence of Decedent  10a. State N A	10c. City, Town or Le	ocation			10d. Inside City Limits
	Mary f sh	tor	MD N/A	Baltimo	re			1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number		10f. Zip-Code		10g. Citizen of What C	ountry?
	h with		6714 Haven	oak Rd # A2	21237		USA	
215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notifled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☐ No Specify.		14. Race - Am Black, Whi Specify:B1	te, etc.
2	72 ho natura ical E	Be Completed	15. Decedent's Ec		edent's Usual Occupation	st of working	16b. Kind of Busines	s/Industry
2	ithin 7 e. an "r Med	nple	Elementary/Secondary (0-12)	College (1.4 or 5.1) life.	DO NOT use retired)	st of Working	Hair Sa	
2	filed within Hygiene. other than " ant, the Mec	Co	11th  17. Father's Name (First, Middle, Last)	N/A COSIII	Ba	ar Maid	Bar and Lo	ounge
Ξ		To Be	Paul N. La	ney		ner's Name <i>(First, Midd</i> rinne Br	ooks	
	s 1 and 2 should be if Health and Menta item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (7 Wayne Kinsler/	· · · · · · · · · · · · · · · · · · ·	ing Address (Street and Numb Havenoak Ro			' '
<u>e</u>	iges 1 and of He		20a. Method of Disposition  1 Burial 2 XCremation 3	Bernoval from State 20b. Place of Disp	matory or other place)	Date	20c. Location - City o	
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Baltimore,	permit. Page Department o Important: If any Injury or once.		21. Signature of the privice Lio	2	2. Name and Address of Facil	on Ave. E	Balto., MD	tie f?S 21223
	Physician		23a Part 1. Enter the disease, or composite the control of the con	olications that caused the death. Do not en ne cause on each line.	ter the mode of dying, such a	s cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):				
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	sit sd	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				1
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ž O	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of d	elivery
X P O	d for	sicia	in the past 12 months? 1 ☐ Yes 2 No	4 Pregnant at time of death 5	□ Ectopic pregnancy     □ Other (specify)		Month	Day Year
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ν̈́.	s thai ned t	by F		ontributing to death but not resulting in the		t I. 23e. Did	tobacco use contribute	to the cause of death?
Hecords,	quire on sig	led	LIVER CIRRHOSIS,	Alcoholism, diabeter	Mellitus	1	Yes 2 No 3 F	Probably 4 🗌 Unknown
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0	Physic this ce ral dire	2	1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatie		ursing Home 5 - Re	sidence 6 - Other (Spe	ecify)
Ĕ	tending Ph leath. or: After thi the funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date Nnjury 28b. Time (Month, Day Year) 1njury	Work?		e how injury occurred	
<u> </u>	uttendii death. ctor: Af y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2			2 12 11
DIVISION	ire ire	Certification:	4 Homicide determined	building, etc. (Specify)		City or To	(Street and Number or a own, State)	
	To the Hospital or within 24 hours after To the Funeral Dir Sompletely filled in	Medical	29a. Certifier (check only one) Certifying Ph	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or i and manner stated.	th occurred at the time, date a nvestigation, in my opinion, de	and place, and due to the toth occurred at the time	ne cause(s) and manner e, date and place, and d	as stated. lue to the cause(s)
	Within To the transfer of the	ž	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	
	( 7/2		Sathak		RESOOO		May 28	2012
	02			completed cause of death (Item 23a) (Type				
			SUJAY PATHA		49	940 Eastern A	Avenue, Baltim	ore, MD, 21224
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature				

DHMH 17 Rev 1/2001 11595

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		1 - State Registrar	aryland / Depa <i>Cei</i>	artment of F rtificate of		vientai Hy	giene Reg. No	0.0	12	1746				
Physic /Medi		1. Decedent's Name (First, Middle, Last)  JOHNNIE D. BARNES				2. Date of De MAY 1	eath Day	201	ear 2	3. Time of Death 20:30 M				
Examir Funeral Director		4a. Facility Name (If not institution, give street and number)	e (In yrs. last birthday) 91 Yrs.	4b. City, Town, o  CAPTTOI  If Under 1 Year  Months Days	HEIGHT If Under 24 Hrs. Hours Min.	PRINCE GEORGI								
Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  DC	10c. City, Town or Lo							0d. Inside City Limits 1 X Yes 2 □ No				
h with the 23a or 28	Funeral Director	10e. Street and Number 2301 11th St., NW #413		10f. Zip Code 2 0 0 0 2				izen of Wha		•				
Ind 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Expriser cust be recitive at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 ☒ Yes 2 □ If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	D-	14. Race - Black, V Specify:	White, e	etc.				
Baltimore, Maryland 21215-0036 bermit. Pages I and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. mportant: If tem 27 is marked other than "natural", or my injury or other traumatic event, the Medical Expriguee.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  MANAGER					ness/Ind	lustry				
aryland 2 should be filed and Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) BENNIE BARNES		MANAGER PRIVA  18. Mother's Name (First, Middle, Maiden Surna  ELLA BARNES						ame)				
re, Maryla 1 and 2 should 1 Health and Mer tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) MICHELLE HAMILTON/DAUGH	ITER 5914	L ST	CAPITOL	HEIGH	al Route Number, City or Town, State  HEIGHTS MD 2 Date 20c. Location - City of			743				
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any Inlury or other once.		20a. Method of Disposition  1		ICOLN CE	$M. \mid 5/2$	Date 6/2012	BR	ENTWO	OOD					
Balti permit. 1 Departm Importal any Inju		21. Signature of Funeral Service Licensee	elley 1	.425 MAR	ess of Facility CA YLAND A	VE NE	WAS			20002				
Physician  *Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ATIONS OF A a consequence of):					1		Approximate Interval Between Onset and Death				
box 68/60, death certificate be executed e attending physician and d for use as the burial-transit	=	Due to (or as d	a consequence of):											
at the death cer by the attendir stached for use	Physician/Medica	23b Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	ру			23d. Date o Month		ery Day Year				
ecords, P.O. law requires that the dias been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death be DEMENTIA	ut not resulting in the u	nderlying cause giv	en in Part I.					e cause of death?				
The la The la ate has	e Completed	ESSENTIAL HYPERTENSION  25. Was case referred to medical			00 81 10	1 □ Yes	psy ormed? 2 <b>X</b> No	dea dea	or to con ath?	psy findings available inpletion of cause of 2 No				
OT VITA Physician: r this certific ral director,	70 B	examiner? 1   Yes 2   No   Hospital: 1   Inpatie	ent 2 ER/Outpatier		4 LI Nursing H	V		6 □Other	(Specify	<i>(</i> )				
To the Hospital or Attending Physical Within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	ertification:	27. Manner of Death  1 Natural  2 Accident investigation  3 Suicide 6 Could not be determined determined	y, Year) Injury ury - At home, farm, str	M 1 🗆	ryat k?  Yes 2 □ No	28f. Location (	be how injury occurred  One (Street and Number or Rural Route Number,							
lospital or hours afte uneral Dir	edical Cert	29a. Certifier  (Check only only of the basis of the basi	of mv knowledge, deatl	h occurred at the ti	me, date and place	City or To	wn, State	and mann	ner as si	tated				
To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	ited.	29c. Licens		rred at the time.	29d. Da	te signed (A	Month, L	Day, Year)				
		30. Name and address of person who completed cause of d SONIKA PANDEY, M.D., VAMC,	eath (Item 23a) (Type,			IGTON - DO								
Sta Registr		31 Date filed (Month Pay Year)	ar's Signature		, mouth									
DHMH 17 Rev 1/2		Total Application	7 7			-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June June 2012 Raymond Caccavalla 9:40 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 071-32-8867 1 № M 2 🗆 F August 1, 1940 Queens, New York **Director** 71 ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Spicewood Burnet Texas 1 Yes 2 X No 10f. Zip Code 10e. Street and Number Og. Citizen of What Country? United States Funeral 78669 705 Parting Lane America items 2 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces' Black, White, etc Il Hygiene. other than "natural", or 1 Never Married 2 Married Yes 2 No þ Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify Specify. Yes, Give ₩Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Supply Sales 12 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Anna Coyle Frank Caccavalla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4406 Silver Teal Road Nottingham, Maryland 21235 Mr. Dave Caccavalla/ son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June June cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) 2012 Forest Hill, Maryland <sup>22.</sup> Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Jun A Service Lig Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter Immediate Cause (Final CAncer Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to lor as a conse quence of: cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 the ! as signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown es Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 1 ☐ Yes 2 ☐ No After this certificate 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No proce ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-License number

State Registrar 6701

Al-Charles St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ 2012 12:40 PM Marlene Carlson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 8412 Cunningham Drive Berwyn Heights If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Director 214-86-2602 1 🗆 M 2 🕱 F 04/09/1941 71 Germany 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Prince Georges Berwyn Heights 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 20740 U.S.A. 8412 Cunningham Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important, If Item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Becker Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8412 Cunningham Dr., Berwyn Heights, MD 20740 Jack W. Carlson / Spouse 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State |Hanover, Maryland 06/04/2012 Anatomy Gifts Registry 4 Donation 5 Other (Specify) Anatomy Gifts Registry 21. Sign wure of Fundal Service License 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Kectal carcinoma with widespread disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence on: burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be exe Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🛪 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Investigation Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 3 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

erson who completed cause of death (Item 23a) (Type, Print)

MD 32. Registrar's Sign

Schissler

29c. License number

022780

7500 Greenay (N. Dr. Creenbelt, MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ornis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewoo Himor 8. Date of Birth (Month, Day, 6. Sex 1 M 2 □ F last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Yrs Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Xyes 2 No timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during life. DO NOT use retired) (Specify only highest grade completed) //Seconday (0-12) Baltimore Be . Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ornist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto, A ornish oan Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory Baltimore, 2012 4 Donation 5 Other (Specify) 21. Sig of Funeral Service Licensee, 21202 Orth a /1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Implemate Cause (Final disease e or condition resulting in death) -Physician/ Medical Due to (or as a consequence of) Examiner ASOVI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the 88 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 2 No Yes P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy prior to completion of death? certificate 1 Yes Yes Division of Vital director, 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Other: 2 🗓 ပု 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; injury work? Matural 5 Pending 2 🗌 No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check з 🗌 only one 29d. Date signed (Month, Day, Year) 29b. Signatu re and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ords MD2123 all 8813 31. Date filed (Month, Day, Year 32. Registrar's signatur State JUN 0 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d, perPHYS, G928, 6/4/2012, WS
State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AM Month 22:11 Physician/ BELLE CALENTINE 4a. Facility Name (if not institution, give street and number) 4c. County of Death Medical 4b. City, Town, or Location of Death Examiner MEDICAL CENTER ANNEARUNDE 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) If Under (Month, Day, Ye Year Country) **Funeral** 1 □ M 2 🛛 F Months Q Yrs. 273-30-1042 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 No ADEN 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 9.S.A, Funeral 21122 AMION Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: WHITE Baltimore, Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CLERK 11 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ၉ CANDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8259 CAMION CT PASADELLA MO. ZIIZZ MARK CALENTINE, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ODENTON, MD. ARUNIZE CREMATORY 5-6-12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DAUGHEATY FUNERAL HOME 2601 MOUNTAIN RD. ASSADENA, MD. ZIIZZ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Difficle Mostridium Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ending physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23d. Date of delivery 23b. Was decedent pregnant Month Year in the past 12 months?

1 Yes 2 No

9 Unknown ō 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy safter death.

I Director: After this certificate has law in hy the funeral director, page 2 s performed? Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 No 1 V Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death
Natural
2 Accident Certificate: injury work 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nifese Practioners to the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours at To the Funeral Di Medical 29a. Certifier (Check only one) 29d. Data-signed (1/2016 102), Year) 29c. License numbe 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 7/2009

State

3

MI

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 0 4 2012

ep

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carlisle 6.15 PM Helen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. Social Security Number 7, Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Director 192-12-4777 June 27,1923 Pennsylvania Yrs 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director New Windsor 1 X Yes 2 No Carroll 10e Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21776 U.S.A. 418 Church St. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) church service center 12 processing/data entry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Erb Roy B. Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 New Windsor Rd., Westminster, MD 21157 Linda Ibex - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadow Branch Cem. 6/5/2012 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home 310 Church St., New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Day 5 Other (specify) 2 1 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ☐ Yes 2 No 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) Bast drain sheet Westwinster HA 211 MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State O NUL 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 June Dudley Barbara Jean Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 102 Dameson Road <u>Edgewood</u> 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Davs Min (Month, Day, Year) **Director** 909-72-9909 1 🗆 M 2 🕱 F 76 02/12/1936 Nebraska Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 102 Dameson Road 21040 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Public School System Bus Driver and Mental Hygie is marked other Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mildred Ninemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Dameson Road, Edgewood, MD 21040 Michael A. Dudley / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 - Other (Specify) Anatomy Gifts Registry 06/04/2012 Hanover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P. Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examin cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Pobably 4 Unknown Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? ty pertension 24a. Was an page 2 performed 2 3 No 1 Yes director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 5  $\square$  Pending 24 hours after death. Funeral Director: A Accident
Suicide Investigation completely filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month Pay, Year)

3. Time of Death

1 Yes 2 X No

21076

Year

A

8:47

Registrar DHMH 17 Rev 06-2011

State

ack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mopth\_ M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Inpatient Care Center Harwood If Under 1 Year If Under 24 Hrs
Months Davs Hours Min. . Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 061-14-9372 Director 1 M 2 91 Yrs July 25,1920 New York 28a-f shov 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland πent of Health and Mental Hygiene. 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Severna Park Anne Arundel 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 41 West McKinsey Road items Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify Completed 3 X Widowed 4 Divorced Year or Dates is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Home** Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evence. Catherine Ritterbush Paul Kastner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 218 Rock Ridge Road Millersville, MD 21108 Luisi / Daughter Doreen 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 06, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Holmdel Cemetery Holmdel, NJ 4 Donation 5 Other (Specify) 2012 21. Signature of Euroral Sorvice Licensee 22. Name and Address of Eacility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease shock, or heart failure le disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest t failure. List only one cause on each line. Immediate Cause (Final nset and Peath Physician/ SMAGE ARADOUNTSCUL disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 1 🗌 Yes Yes 2 L 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated early local place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

551

State Registrar 39. Name and address of pe

STENEN TUE 31. Date filed (Month, Day, Year)

JUN 0 4 2012

DEFENSE

cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ ERGU SUI Medical **Examiner** 4a. Facility Name (if not institution, give street and number, or Location of Death 35 Quantico Ave tumur Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth Min (Month, Day, Year) Director රි pland ms 23a or 28a-f show must be notified at 10b. County the Maryland 10c. City. Town or Location **Funeral Director** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items? Page 1 and 2 should be filed within 72 hours after death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever ip 14. Race - American Indian Examiner Armed Forces? Black, White, et ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 🗆 🛂 If Yes, Give 3 Widowed 4 Divorced "natural", Specify: Completed Year or Dates er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life) DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Su ပ nas Informant's Name/Relationship (Type, Print) or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number Health a Department of Healt Important: If item 2 any injury or other injury or other Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) arrison tare of Funeral Service Licen 21. Signal 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. tions that caused the death. Do not enter Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as IF FEMALE nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for the Hospital or Attending Physician: The law requires that the death in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 2 No be detached the 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation filled in by the Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Linda Jacqueline Fortney Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Baltimore Washington Medical Center Glen Burnie 9. Birthplace (State or Foreign 5 Social Security Number 6 Sex Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 1 🗆 M 2 🛚 X (Month, Day, Year) 1944 216-44-5663 67 New Jersey Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director Glen Burnie MD Anne Arundel 1 🗌 Yes 2 💢 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21060 7575 E. Howard Road USA items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🗓 No Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Home** Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is many injury or other ပ Frank Wark Hazel Wark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Perdue / Granddaughter 7881 Brighton Court Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 01 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place, Baltimore, MD Metro Crematory, INC Donation 5 Other (Specify) 2012 of Funeral Tryle Li Signatur CREMATION DIRECT Severna Park, MD 21146 495 Ritchie Hwy, t 1. Enter the disease shick, or heart failure. L inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ehmonia Ph\_sician/ 10) disease or condition resulting in death) or condition Medical Examiner Sequentially list conditions, cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? been signed by the atte should be detached for a Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy this certificate 2 No 1 Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a d title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. 2012 17477 State of Maryland / Department of Health and Mental Hygiene

	- 1	1- For State Certificate of De	eath	Reg. N	o				
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death     Month Day	/ Year	3. Time of Death 2032 hrs			
ledical Examin		DAVID DALE FARR  4a. Facility Name (if not institution, give street and number)  4b. 0	City, Town, or Location of Death	May 18, 2012	4c. County of Death	2032 1115			
			ockville		Montgomery				
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	M/DD/YYYY) 9. Birti	nplace (State or					
Director	-	$215-64-3596$ $_{1}X_{M}$ $_{2}F$ $_{59}$ $_{Yrs.}$	Months Days Hours Min	10/25/	1952 Foreign	intry)O			
	- 1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
ow any	- 1	10a. State 10b. County 10c. City, Town or Location MD MONTGOMERY GERMANTOWN				1 Yes 2 X No			
Maryland 28a-f show d at once.	횽		f. Zip Code	10g. C	itizen of What Coun	try?			
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once.	Director	19515 FREDRICK LANE #73 20876 USA							
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	ecedent of Hispanic Origin? ( Specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,			
r death	딃	Never married 2 X married 1 Yes 2 X No			Specify: WHI'	тE			
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	ete	Elementary/Secondary (0-12) College (1-4 or 5+)		APARTMEN'	TT C				
5-0036 led within 72 hours a Hygiene. I other than "natural the Medical Examin	Completed	12	ANCE MAN			15			
		17. Father's Name (First, Middle, Last)		e (First, Middle, Maide S JEAN SI					
2121 uld be fil Mental I marked	o Be	GENE GALEN FARR  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Ad	dress (Street and Number or I			Zip Code)			
Baltimore, MD 212 permit. Pages I and 2 should be Department of Health and Menta Important: If Nem 27 is mark injury or other traumatic even	۱-	FRANCES FARR - MOTHER 131 BO	ADE, CO	81526					
Te, Tand I and Healt Fitem	ı	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition crematory or other p		Date 200	c. Location - City or T	Fown, State			
Baltimore, permit. Pages 1 an Department of He Important: If ite		4 Donation 5 Other Specify: ATLANTIC	CREMATORY 5	5/27/12	GLEN BUR	NIE, MD			
Salti epartir nports	Ì	21. Signature of Funeral Service Licensee 22. Name	and Address of Facility	KARDA FUI	NERAL HO	ME			
	4	M01120 282  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	9 HUDSON ST.	BALTIMO	ORE, MD	21224 Approximate Interval			
Physician /Medical		failure. List only one cause on each line.				Between Onset and Death			
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)  a. UXYCOGONE and Cocaine.  Due to (or as a consequence of):	incoxicación						
	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):							
	Examine	Cause Finter Underlying Couse (Disease or injury that initiated			7				
red msit	Ä	events resulting in death) Last  Due to (or as a consequence of):  d.							
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760, cate be physic the bur									
certiff	E	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal d Pregnant at time of death 5 Other	leath 3Ectopic pregna (Specify)	ancy	Month D	ay Year			
Box 687 ne death certific	Physician/	1 Yes 2 No 9 Unknown 9 Unknown							
P.O. res that the signed by be detach	b P	Part ii. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		No. 3 Prob	he cause of death? ably 4  Unknown			
ls, P.C quires that en signed l	절	allow it.		24a, Was an		opsy findings available			
cords, law requin has been s	Completed			autopsy performed	prior to co death?	ompletion of cause of			
tal Rec		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 🗸 Yes	2 No			
Vital I hysician: this certifi	å	examiner?   Hospital: 4   Innation: 2   ER/Outpatient 3		ng Home 5 Resi	dence 6 Other:				
of on ng Phy	24a. Was an autopsy performed?  1								
ttendi death. rtor:	읥	Natural 5 Pending Investigation fd 5-18-12 fd 7:55 g		unknown					
Jivis al or A safter al Dire	Certification:	3 Suicide 6 X Could not be determined (Specify) Found: Residence	actory, office building, etc.	or Town, State)	19515 Fred	al Route Number, City			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place, and	due to the cause(s)	omery Cour and manner es state	d.			
To the F within 2. To the F complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death occurred a	at the time, date and p	olace, and due to the	cause(s)			
FSFS	ž	29b. Signature and title of certifier	29c. License number		d. Date signed (Mon	th, Day, Year)			
		() Cartakerine	O.C.M.E.	M	ay 19, 2012 —————				
	ſ	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltin	nore Street, Baltimore.	MD 21223					
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
		near 0 4 2012							

**ORIGINAL** 

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:00P Physician/ 1, Day 12 Year JMTE Frank John Ferrell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 216-20-5814 1 🕅 M 2 🗆 F **Director** 86 Feb. 10, 1926 Maryland Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Maryland Baltimore Cockeysville 10e. Street and Numbe 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral U.S.A. 21030 3 Furnace Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔽 No Specify "natural", 3X Widowed 4 □ Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working College (1-4 or 5+) life. DO NOT use retired) Elementary/Secondary (0-12) vears Budget Director NASA Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Amos Ferrell Veronica Sadowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane L. Marsiglia (daughter) 3910 Dance Mill Road Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Page 1 1 X Burial 2 Cremation 3 Removal from State 6-5-12 Dulaney Valley Mem Grdns 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Signature of Funeral Service Licensee Mitchell Wiedereld Funeral Home, 6500 York Road Baltimore, Mary enan 21212 23a. Part 1. beter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phyllician. MULTIPLE SYSTEM ORGAN FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner GRAM NEGATIVE BACTEREMIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) URINARY TRACT INFECTION The law requires that the death certificate be executed Exam and I-tra Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Box 68760 attending phys the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) Yes 2 No 1 ☐ Yes ≥ ∟ 9 ☐ Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N 2 🗆 No Yes 1 🗌 Yes After this certification and all the second and all the second all the second and all the 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be examiner? 1 Yes Other: 2 **X**No 1 XInpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred 1 XNatural 5 Pending work 2 Accident
3 Suicide within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Hospital

DHMH 17 Rev 06-2011

Medical

29a. Certifier

3 🗆

TIMOTHY LOW, M.D. Day, Year)

JUN 0 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifier

1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D24034

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7601 OSLER DRIVE TOWSON, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0.5 Month Clifford Allen Forrest 25 2012 6:55A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchirst Baltimore N/AIf Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Funeral 5 Social Security Number 2 1 2 - 6 0 - 8 8 0 3 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 1 M 2 - F Yrs. 58 11/04/1953 Maryland rai", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2611 Springhill Ave. Pega 1 end 2 should be filed within 72 hours aftar death v nent of Heelth and Mentel Hyglene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 X Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nt of Heelth and Mentel Hygiene.
: If item 27 is marked other than or othar traumatic event, the Ms Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Entrepreneur Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Bowlware Margurite Hazel Forrest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207Melissa Thomas(daughter) 3916 Liberty Heights Ave. T2, Balto., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Depertment in important: If any injury or once. on-site Crematory 05/01/12 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service, License 30sephodfs: of Brown Jr. Funeral Home PA ruc 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ready Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami 4 Hospital or Attending Physician: The lew requires that the deeth certificate be executed 24 hours efter death.
124 hours efter death.
24 hours efter death.
35 Foundaria Director: After this certificate hes been signed by the attending physicien and letely filled in by the funeral director, page 2 should be detached for use as the burlel-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔊 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 (A)No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical To tha Hosp within 24 hou To tha Funel completely fi 29a. Certifier 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 25 USBSOS MA 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chriles Nova 6701 ST TOWSON M 31. Date filed (Month, Day, Year) 32. Registrar's agnature State JUN 0 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GRIMES UTH 2:00 A M May Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll Social Security Number If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) Director 213-16-0114 1 🗆 M 2 🔀 F 96 Oct. 7, 1915 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21787 6 Commerce St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Force by 1 Never Married 2 Married 1 Yes If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien is marked other th 8 assembly line worker rubber factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. Maurice Horner Orphie Anders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Grimes/daughter-in-law 6 Commerce St. Taneytown, MD 21787 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oak Hill Cemetery 6/1/2012 Legore, MD 22. Name and Address of Facility Hartzler Funeral Home, P.A. Signature of Funeral Service Lice Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that govern the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e Respigator Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last SHE Due to (or as a consequence of) Physician/Medical that the death certificate be the attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ※ No 24a. Was an page 2 or Attending Physician: The 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Yes ည 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 🔼 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 5 Pending Division 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, languliza, MD 51705 05-29-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Westminster Mulcolm 349 175 M. PANSURIYA 31. Date filed (Month, Day, Year) 37. Registrar's Signature State

Registrar

P	uted		pu	
_	Jospital or Attending Physician: The law requires that the death certificate be executed		Tuneral Director: After this certificate has been signed by the attending physician and	
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1	20a. Method of Disposition	20b. Place of Disposition (Name of ceme	etery,	Date 20c.	own, State							
	1 V Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens 22. Name and Address of Facility CAWIN L. WILLIAMS F.S., P.N. 5913 Robin dak Rd. Bollo. MOR.											
	4 Donation 5 Other Specify:	FAIRUIEN AME.	30 E-65	5-2012 F	Luia forrest Hill, Mio							
	21. Signature of Funeral Service Licens	22 Name and Address of	f Facility	Ans IS	ON.							
, ly	Calvin Latino	5913 Robin	Idak R	1. Bon Her	102/	228						
	23a. Part I. Enter the disease, or complications that caused the	ne death. Do not enter the mode of dying, su	uch as cardiac or r	espiratory arrest, sho	ock, or heart	Approximate Interval Between Onset and						
	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):											
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ē	if any, leading to immediate Due to (or as a conseq	uence of):										
늰	if any, leading to immediate cause. Enter Underlying Cause (Classes or in the year that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):											
ğ	events resulting in death) Last Due to (or as a consequence of):											
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₹	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the		1		d. Date of delivery							
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	Part ii. Other significant conditions contributing to death b	out not resulting in the underlying cause give	en in Part I.		use contribute to th							
Be Completed by				1 Yes 2 ₩	No 3 Probal	oly 4 Unknown						
ig.				24a. Was an	24b. Were auto	psy findings available						
희			<del></del>	autopsy performed?	prior to cor death?	npletion of cause of						
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ပ္က	25. Was case referred to medical	26.Place of	Death (Check on	ly one)								
	examiner?  Hospital: 1 Inpatient		her Nursing		nce 6 Other S	20000						
리	1 Yes 2 No Inpatient 27. Manner of Death 28a. Date of Injury			8d. Describe how inju		cella						
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黃	2 Accident Pending Problem May 28, 2012	1930 hrs	5 2 ✓ No	,								
ű	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number)											
뒿	4 Homicide determined (Specify) Bay		lc.	or Town, State) hesapeake Bay- S	W Flats. Betterto	n. MD						
Medical Certification: To	29a Certifier					.,						
g	(Check only   Certifying Physician: To the best of my k	mowledge, death occurred at the time, date nation and/or investigation, in my opinion, d		, ,		(a)						
듛	and manner stated.	autori and/or investigation, in my opinion, d	eath occurred at ti	nie ume, date and pla	ice, and due to the t	ause(s)						
žΙ	29b. Signature and title of certifier	29c. License r	ıumber	29d. l	Date signed (Month	, Day Year)						

O.C.M.E.

May 29, 2012

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Carol H. Allan, MD 31. Date filed (Month, Day, Year)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b &c Per FH G928 6/06/2012 JH State of Maryland 7 Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ , 2012 JOHN **GUTRIDGE** 4:30A VINCENT JUNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Days Hours Min Director 216-80-9348 XX M 2 D F 45 07/23/1966 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Baltimore 1 Tes 2 XXNo Baltimore 10e. Street and Number 5 10f. Zip Code 10a, Citizen of What Country? Funeral 23a 111 Dunkirk Road 21212 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. an "natural", or ite Medical Examiner Armed Force Black, White, etc. \$ 1 Never Married 2 Married Yes 2 XXNo RICC, JOHN VINCUM Baltimore, Maryland 21215-003 1 ☐ Yes 2XX No Specify: 3 Widowed 4 XXDivorced White Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Chef Restaurant. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard Glenn Gutridge Jane Frances Singleton Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Glenn Gutridge Father 111 Dunkirk Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of **Duckarsey**en**Valley**er p**Mem Gardens** 1619 Cross Corretery 06/04/2012 Timonium 1XX Burial 2 Cremation 3 Removal from State -Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Stephan Jennio Res 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ACUTE RESPIRATORY FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HEPATIC FAILURE Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of burial-transi and Due to (or as a consequence of): physician Physician/Medical certificate be P.O. Box 68760 the as pulpi IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atten jo in the past 12 months? Month Day Year 2 No the 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ALCOHOLISM Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen CHRONIC THROMBOCYTOPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 XNo certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 **X** No 잍 1 Tyes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending in 24 hours after death.

Refuneral Director: Af pletely filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License numbe D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOSROW TABASSI, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year) State Registrar JUN 0 4 201

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012

		1- For State Registrar					Cert	tificat	e of	Death			,		Reg. N	lo.		
Physici	an/	1. Decedent's Name	e (First, Midd	dle,Last) 2. Date of Death								3. Time of Death						
edical Exami	iner	Ronald Hard	desty					Month May 3					Day Year 31, 2012			1053 hrs		
		4a. Facility Name (i	(if not institution, give street and number)  wood Lane					4b. City, Town, or Location of Death Bel Air							4c. County	of Death		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Bir								tholace (State or								
Director		220-64-9542		1X N	1 2 F	, , , , g , ,		58	Yrs.	Months	Days	Hours		Jan.		1954	Foreig	
Ą		Usual Residence of				140	c. City, 1	T	1									
w any			10b. County			100	•		Locatio	rı								10d. Inside City Limits  1 Yes 2 No
land f sho	Į0	Maryland	Harfo	ard			Bel i	Air										
Mary 28s	Director	10e. Street and Nur	mber							10f. Zip (	Code				10g. (	Citizen of W	nat Cour	ntry?
h the	Ö	419 Underv	wood Lar	æ						210	14				U.S	S.A		
death with the Maryland or items 23a or 28a-f show must be notified at once.	uneral	11. Marital Status  1 Never Marrie		arried	12. Was De Armed F		er in U.S	5. 1						ecify Yes or Rican, etc.)	No-	14. Race White		can Indian, Black,
or it	Ē			- 1	1 Yes	2 X	No No							,				
s afte	Ą	3 X Widowed  15. Decedent's Ed			Yes, Give Ye		atod)	160 Do		res 2	X No		bind of	adr dana	Specify: White			
2 hours afte "natural", Examiner	Completed	Elementary/Seco		I I		1-4 or 5+)		dui	ring mos	st of work	ng life. D	OO NOT	use retire	ed)	loc	. Kind of Bu	ISINess/II	ndustry
36 hin 72 than	ple	Ziomoniary/0000	daiy (0 12)	- [	oonogo (	2		Weld	br						la	nstruc	tian	
5-0036 ed within 7. tygiene. other than	Š	17. Father's Name (	(First, Middle	, Last)							18	.Mother	s Name	(First, Midd	_	en Surname		_
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be (	David Ha	ardesty									Mitzi	ie Hut	chinso	n			
21 ould t	2	19a. Informant's Na	me/Relations	hip (Typ	e, Print )			19b. Mailing Address (Street and Number or R					ber or R	ural Route I	lumber,	City or Tow	n, State,	Zip Code)
p, MD 21215-0036 and 2 should be filed within 72 hours after leafth and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner		Mitzie Smi	ith (Mo	other)	)			] 3	30112	Fran	kford	Scho	ol Ro	ad, Fr	ankfo	ord, DE	1994	<b>!</b> 5
Te, I and I then		20a. Method of Disp			l Damaunia	Ctat-				on (Name			~	Date	200	c. Location -	City or	Town, State
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland to of Heath and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f she is rother traumatic event, the Medical Examiner must be notified at once		1 Burial 2 3	-		Removan	TOTH State	Evar		ilera 21 Ai		ET		June 201	12	F	orest H	ill,	Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med					• Jeffr	ey R.	Test				ddress o	f Facility	/mm] 8	Chromo	tion	Contin	~	Pol Nir
00 89 3 E		21. Signature of Fur	K Te	stel	man	<u> </u>	(MO1	543)	<u>3</u> °	Newpo	rt Dr	ive,	Fore	t Hill	, Mai	ryland	21050	)
Physician		23a Putil, Enter the	e disease, or y one cause	complication each	ations that of the line.	caused the	death. [	Do not e	nter the	mode of	dying, su	uch as ca	ardiac or	respiratory	arrest, s	hock, or hea	art	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (I	Final disease		traoral G													Death
		or condition resulting	ig in death)	Du	e to (or as	a consequ	ence of):	:										
	-	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):																
	틭	cause. Enter Under		c														
Dist. Te	Examine	events resulting in death) Last Due to (or as a consequence of):																
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	/Medical	UNPENDED		<b>┐</b> ╬┈	AMENDED													
50, te be nysici	Peg	IF FEMALE:		1-	23c. If yes,	outcome :	of pregna	ancv							12	3d. Date of	deliven	
3876 rtificat ing phy as the		23b. Was decedent p past 12 months			1 Live			2	Feta	l death	3	Ectopic	pregnan	су	- [	Month	_	ay Year
Box 68760, death certificate be he attending physici di for use as the buri.	Physiciar	1 Yes 2 N	_	4 Pregnant at time of death 5 Other (Specify) Unknown 9 Unknown														
he de hed f	چ	Part II. Other signif					it not con	ultino in	thous	dorluina a	oues eiu	on in Da	et I	230 Di	d tobaco	o uso contri	huta ta t	he cause of death?
ires that the signed by I be detach	ð	Ture in Outor organi	iodii ooiidii	10110	oran batang t	o deali i bi	at flot res	salang n	i ti io ti i	aerryn ig c	ausa givi	en ni i a			Yes 2		_	ably 4 Unknown
duires	Completed													24a. W				opsy findings available
COTC law re has be	륄		<u></u> .											au	topsy rformed	р		ompletion of cause of
	등													1 <b>✓</b> Ye	s 2	No 1	Ye:	s 2 No
cian: certif ector,	B	25. Was case referred examiner?	ed to medica	l Hos	nital:						104	har -	Check or				-	
of Vital Records, ng Physician: The law require After this certificate has been si nneral director, page 2 should b	은	1 Yes 2 27. Manner of Death	2 No		الان ا	Inpatient of Injury		R/Outp			c. Injury a	ب				dence 6		Scene
n of iding P. h. : After	<u></u>	1 Natural	5 Pend	lina	FOUND	n, Day,Year)	'   î	FOUN!		-	c. ⊪ŋury a 1 Yes		lo	Subject s			au .	
SiOl Attender r death ector: by the	cat	2 Accident	Inves	stigation	May 31	, 2012 ce of Injury		1053 h						Of Location	o /Strani	and Numbe	or Dur	al Route Number, City
Division of Vital   Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifiely filled in by the funeral director,	Certification:	3 Suicide		d not be rmined		Mobile			, sucet,	ractory, c	ince buil	ung, en		or Town	, State)	ane, Bel Ai		al Route Number, City
Iospit 4 hour funer		4 Homicide  29a. Certifier	Certifying Pi	hysician					occurre	d at the ti	me date	and plac					-	d
the sin	edical	(Check only	Medical Exa	miner:0	n the basis	of examin												
To vith	Æ	29b. Signature and t	title of certifie		nd manner :	olaled.	\			29c. l	icense r	number			290	I. Date signe	d (Mon	th, Day, Year)
		AN.	1. 1.	3,0	11/1	M	L)				D.C.M.	Ε.			Ju	ne 1, 201	12	
0	ŀ	30. Name and addre	ess of person		npleted cau	se of deat	h (Item 2	23a)							_1_	-		
10		Melissa Bras	ssell, MD	Assi	stant Me	edical E	xamine	er 90	00 W.	Baltimo	re Stre	eet, Ba	altimore	e, MD 21	223			
	ate	31. Date filed (Month		040	72. R	egistrar's	Signature	9 /		,								<del></del>
Regist	rar		1042	U12	Russ	M.	B.	400	Na									

Brendan James Huber

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 17484

		1- For State Registrar		Cei	rtificate o	f Death			Reg.	No.			
Physic		1. Decedent's Name (First, Middle,Last)							Date of Death Month	Day	Year	3. Time of Death	
Medical Exam	iner	Dictidati of made							1ay 19, 201	12		2235 hrs	
		4a. Facility Name (if not institution, give street and number)  6 Lord Mayors Court  4b. City, Town, or Location of Death  Cockeysville							4c. County of Death Baltimore County				
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea Months Day		24Hrs. 8 Min.	Date of Birth	(MM/DD/Y	Foreign	hplace (State or	
Director		215-25-6971	1XM 2 F	23	Yrs		Tiodis		April 2	21, 1	1989 °°	intr <sub>Maryland</sub>	
any		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Local	ion						10d. Inside City Limits	
		MD. Balti	more		keysvil							1 Yes 2 X No	
Maryland 28a-f show d at once.	cto	10e. Street and Number							10g	. Citizen o	of What Coun	try?	
5-0036 leg within 72 hours after death with the Maryland yegene. other than "matural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Director	6 Lord Mayo	rs Court			21030	)				USA		
h with	Funeral	11. Marital Status		cedent Ever in U.	.S. 13. Wa	s Oecedent of His	spanic Origi	n? ( Specif	y Yes or No-		Race - Americ White, etc.	can Indian, Black,	
r deat or ite	ᇤ	1 X Never Married 2 M	1 Yes	2 X No							r 71	<b>.</b> + 0	
rs afte ural",	ρ	3 Widowed 4 Div	vorced If Yes, Give Yes		16a Deceder	Yes 2X No	s <i>pecify</i> :	ind of work	done 1	Spec 6b Kind o	of Business/In		
2 hour	ted	Elementary/Secondary (0-12)		-		ost of working life				00. 14.14	or 5 40111000111	daviy	
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	Completed		2	-	Stude	nt				Educa	ation		
5-0 iled wi Hygier the M	ပ္ပြဲ	17. Father's Name (First, Middle							st, Middle, Mai	iden Surn	ame)		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be		luber						Burke			. <del></del>	
O \( \frac{1}{2} \) \( \frac{1} \) \( \frac{1} \) \( \frac{1}{2} \) \( \frac{1}{2} \	To	19a. Informant's Name/Relations Lawrence Huber/							ural Route Number, City or Town, State, Zip Code)  Cockeysville, MD. 21030				
<b>2</b> 2 4 2 8		20a. Method of Oisposition			Place of Dispos	sition (Name of ce		Da			tion - City or 1		
Pages 1		1 Burial 2 X Cremation		OIII State	crematory or ot	herplace) Service (		5-22-	12	Tows	son, M	D	
Baltimore, permit. Pages I an Department of Hea Important: If itel injury or other tr		4 Donation 5 Other S		HT	22.1	lame and Address							
Dep Dem		21. Signature of funeral service Ligensee 22. Name and Address of Facility Ruck Towson Funer 1050 York Rd. Tow								vson, Md. 21204			
Physician	-	23a. Part I. Enter the disease, or failure. List only one cause	complications that o	aused the death	. Do not enter t	he mode of dying,	, such as ca	rdiac or res	piratory arrest	, shock, o	r heart	Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final disease		ic Intox	ication	1						Death	
		or condition resulting in death)		consequence o	f):								
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.											
kecuted 1 and - transit	Exa												
760, cate be execut physician and he burial - tra	/Medical	X UNPENDED	AMENDED .	4a, per	me,g92	8 6-4-12 928 6-5-1	SM 12 cm						
760, reate by physicate busicate ₩.	IF FEMALE:	23c. If yes,	outcome of pregi	nancy						te of delivery			
Sox 68 leath certifi e attending for use as								pregnancy	ncy Month			Day Year	
Box 68 e death certif the attending ed for use as	Physiclar	1 Yes 2 No 9 Uni	known 9 Unkn		5 O	her (Specify)							
that the d									23e. Did tobacco use contribute to the cause of death?				
ires that signed be deta	d by							_	1 Yes 2 No 3 Probably 4 Unknown				
ords, w requir	lete							- 4	24a. Was an autopsy	24		opsy findings available ompletion of cause of	
Recol The law icate has page 2 sl	Completed							_	performe 1 ✓ Yes 2	ed? No	death?	2 No	
tal Recian: The certificate	Be	25. Was case referred to medica				26.Place	of Death (0	Check only	one)				
of Vital Records, P.O. og Physician: The law requires that the Affer this certificate has been signed by meral director, page 2 should be detacl	를 E	examiner? 1 ✓ Yes 2 No			ER/Outpatient			Nursing Ho			6 V Other:	Scene	
<b>-</b>		27. Manner of Death  1 Natural 5 Pend	,	of Injury , Day,Year)	28b. Time of I		ry at Work? Yes 2 🕱 I		. Describe hov known	v injury oc	curred		
SiOr Attend r death ector: by the	cati	2 Accident Inve	stigation Id 5	-19-12	fd 10:2	20 pm		286	Location /Stre	et and Ni	umber or Rur	al Route Number, City	
Division pital or Attendion strenges after death.  Jeral Director: Affilled in by the fi	Certification		Id not be (Specify)		d:Resid		Juliuling, Oto.	Co	or Town, State	e)6 Lo	rd May	or Ct.	
file ou		20a Cartifian	hysician: To the bes				ate and plac						
To the Hos within 24 h To the Fun completely	Medical		miner:On the basis and manner s		nd/or investiga	tion, in my opinion	n, death occi	urred at the	time, date and	d place, a	nd due to the	cause(s)	
	ž	29b. Signature and title of certific	er			29c. Licens					signed (Mont	th, Day, Year)	
		Madake	ell)			O.C.I	M.E.			May 20,	2012		
	[	30. Name and address of person	who completed cau			Itimora Ctra	d Dalline	ore MAD	21223				
				egistrar's Signatu			ה, טמונווווו	UIE, IVID				<del></del>	
S Regis	tate trar	JUN 0 4 2012	Berry	A do	4.5								

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Name (First, Middle, Last) 1. Deceder 2. Date of Death Physician/ 3:39 M 7016 Medical 4a. Facility Name (if not institution, give **Examiner** 4c. County of Death ltimore N/A rs last birthday If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Director 220-24-8981 1 M 2 F 89 31/1922 MD Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 1 🔀 Yes 2 🗆 No MD N/A Baltimore 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 613 Roundview Rd. 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black "natural", 3√□ Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the N/A Home Maker 12th Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Walter E. Gaines Edith Johnson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and 2 st Important: If item 27 is any injury or other transonce. Edith Wooden-Daughter 613 Roundview Rd. Baltimore, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cheltenham Cemt. 1 X Burial 2 Cremation 3 Removal from State 5/30/2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) March F/H-East 1101 E. 21. Signature of Funeral Service Libensee 22. Name and Address of Facility North Ave. Baltimore, MD 21202 23a. Part 1. Mer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Rhysician/ disease or condition Medical resulting in death) Examiner wenth Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examir resulting in death) Last Due to (or as a consequence of) physician Physician/Medical certificate be Box 68760 the as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yer 2 ☐ No Month Day Year Pregnant at time of death the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate Yes 1 🗌 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to edical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ပ္ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After atural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed

31. Date filed (Month, Day,

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:12 M 2012 GERALDINE HORTON MAY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death
PRINCE GEORGE'S FORESTVILLE FORSETVILLE NURSING HOME if Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Director 249-86-8036 62 Jun 9. 1949 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits Director notified or 28a-f 1 XYes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 1400 Florida Ave., N.E. 20002 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Force þ 1 Never Married 2 Married Yes 2 No 21215-0036 1 Yes 2 No Specify. If Yes Give 'natural", B1ack 3 Widowed 4 Divorced Completed Year or Dates I Hygiene. other than "natura rent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Bus Attendent Government 12th and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Green, Sr. Martha Mae Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keisha Horton / DAUGHTER SE #101 St., <u>Wash., DC</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. Chesapeake Crem. Beltsville, Md. 22. Name and Address of Facility Capitol Mortuary, 21. Signature S Funeral Service Lice Ave. NE 23a. Part 1. Enter the disease, shock, or heart failure. Li Approximate Interval Between Onset and Death or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ) i Sease edebdo Vascylar disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CROUSE Sequentially list conditions, Physician/Medical Examiner if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 205100 that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregna
☐ Pregnant at time of death 5 ☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2X No Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use compute to the cause of death? þ Hospital or Attending Physician: The law requires Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Tes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 흔 Other: 2 No 1 🗌 Inpatient 2 🔲 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \(\sime\) Yes 1 XNatural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completely f (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYEI Glen 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donna 2012 Jones :35 MAY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A AGNES TIMORE Social Security Number 7. Age (In yrs. last birthdav) If Under 6. Sex If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 27,1964 Unknown Months 48 Yrs. **Director** 1 🗆 M 2 🔀 F pril MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he matified at 10c. City, Town or Location
Baltimore 10b. Count 10d. Inside City Limits **Funeral Director** N/A MD Yes 2 No 10f. Zip Code 21216 10e. Street and Number 2622 W. Lafayette Avenue 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Specify. þ 1 Never Married 2 Married 2 😿 No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 № No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hair Salon Elementary/Secondary (0-12) College (1-4 or 5+) Cosmetologist 12th 2yrs Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname)
Zeater Mae Toye ၉ Johnny Davis 19a. Informant's Name/Relationship (Type, Print)
Taylor Jones/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2912 W. Mosher St. Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place Metro Crematory 6/6/2012 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly D. Cros 2700 Edmondson Ave. Balto., Signature of Funeral Service Licensee Cromartie F/S 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CHASTRIC AND ESOCHASETY disease or condition Medical resulting in death) **Examiner** DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the 9 E Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate In 2 🗌 No 1 Tes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: ည 1 Yes 2 🗀 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) - Ronqui la MAY 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNES JONATHAN Registrar's Signa State

Registrar

JONE:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3, Time of Death Decedent's Name (First, Middle, Last) of Death ARVIS Physician/ une Medical Facility Name (if not institution, give street and number) **Examiner** 4c. County of De Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Director M 2 D F 5 or 28a-f show with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Funeral Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No 10g. Citizen of What Country? be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 M Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea ife. DO NOT use retired) Elementary/Secondary (0-12) Con ge (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Pr. Town, State, Zip Code) MD 21 207 Sestor Place of Disposition (Name of Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heaf failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has performe 1 Yes 2 200 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 esidence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contrying Nurse Fractitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contrying Nurse Fractitioner: To the basis of my knowledge could not made at the time, date and place, and due to the cause(s) and manner stated Contrying Nurse Fractitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributed to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of th

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1720 M AMES 115 Medical 2000 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE If Under 24 Hrs. 7. Age (In vrs. last birthday If Under Birthplace (State or Foreign Country) **Funeral** 8 Date of Righ Months Min. **Director** 1 🗆 M 2 🕱 F 86 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD1 ¥Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 33rd 21218 death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 ₩Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Menone. Elementary/Secondary (0-12) College (1-4 or 5+) JOHN HOPKINS ab Tech Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shaded James Dennis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State 6/6/2012 Baltinure, Md National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERALS CVS PA 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director: After this certificate has mpletely filled in by the funeral director, page 2: performed' Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital ျ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 00053539 30. Name and address of person who completed cause of Butimore, MD 21218 201 Bast University State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

evan Jones	State of Maryland / Department of Health and Mental Hygiene  1-For State Registrar  Certificate of Death Reg. No. 2012 174										
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of Death									
		4a. Facility Name (if not institution, give street and number)  Westbound Route 100 at Route 29  4b. City, Town, or Location of Death  Ellicott City  4c. County of Death  Howard									
Funeral Director		5. Social Security Number 214-15-3734 6. Sex 17. Age (In yrs. last birthday) 25 yrs. 18 Days Hours Min. April, 16, 1987 Foreign Md.									
Maryland r 28a-f show any ed at once.	Director	Usual Residence of Decedent  10a. State									
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	by Funeral D	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No 17. Yes 2 No specify:  14. Race - American Indian, Black, White, etc.  15. Yes 2 No specify:									
1215-0036 de filed within 72 hours afte featal Hygiene. narked other than "natural", event, the Medical Examine.	mpleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Landscaper  16b. Kind of Business/Industry  Landscaping  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)									
21215-0036 hould be filed within 7 ad Mental Hygiene is marked other than rife event, the Medica	To Be C	Harry S. Jones  Judith Watkins  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
re, M s 1 and 2 of Health of free 2		Judith W. Jones  3805 Thoroughbred Lane, Owings Mills, Md. 21117  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, All Saints Cemetery June 4, 2012 Reisterstown, Md.									
Baltimore, permit Pages I at Department of He Important: If ite		4 Donation 5 Other Specify:  21. Signature of Fundal Service Licensee  22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md.211.									
Physician Medical Examiner	Jr.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Approximate Interval Between Onset and Death  Death  Death  Death									
be executed cian and irial - transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):  d.									
	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED 23a, 27, 28a-f, per me, g928 6-11-12 sm  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown  23d. Date of delivery Month Day Year									
Records, P.O.  The law requires that the fifcate has been signed by rage 2 should be detach.	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1									
of Vital Rec ng Physician: The la ufter this certificate h neral director, page 2	B	25. Was case referred to medical examiner?  1									
ivision of or Attending Phaner death. Director: After t	Certification: To	27. Manner of Death  1 Natural 2 X Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?  1 Yes 2 X No 28d. Describe how injury occurred Subject was operator of motorcycle that struct a vehicle and was printed underneath the vehicle 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  Roadway  28d. Describe how injury occurred Subject was operator of motorcycle that struct a vehicle and was printed underneath the vehicle 28e. Location (Street and Number or Rural Route Number, City or Town, State) Westbound Rte 100 at Rte 29 Ellicott City, MD.									
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
		O.C.M.E. May 31, 2012  30. Name and address of person who completed cause of death (Item 23a)									
St	ate	Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
Regist		JUN 0 4 2012 Leve B. Sales									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ tancis 01:17 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign MA Boston, 8. Date of Birth Sex 1 X M 2 □ F **Funeral** Months Davs Hours Min. April 24 Year) 1933 023-24-5366 79 Yrs Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Tes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Commerce St. 21078 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1950 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes 2 X No Specify. Specify: White "natural", 1953 3 X Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, College (1-4 or 5+) Elementary/Seconday (0-12) d Mental Hygiene. marked other tha HVAC - Technician 12 Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James McLean Rita Steinman t. Page 1 and 2 should by tment of Health and Mer tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Lewis (Friend) 620 Concord Street, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 Durial 2 X Cremation 3 Removal from State June 2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Air Testern at me and Address of Facility

15.43\ Evans Funeral Chapel & Cremation Service — Bel Air Signatura of Funeral Service Licenses Jeffrey (M01543)UNKAN 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ アクスとり disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death
Unknown 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 Hospital Other 2 🕱 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🎾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ corine 02:32 am 2012 Murchison mai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15altimore Baltimore Maryland niversity of Medical If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Country) 247.26-0070 Hours Min (Month, Day, **Director** 1 □ M 2 👿 F ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director timore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21222 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Blac and Mental Hygiene. is marked other than "natural", 3 ₩ Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementa y/Secondary (0-12) College (1-4 or 5+) orke Be o Town, State, Zip Code) 20b. Place of Disposition (Name of gemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Sign vure of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate ailure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner nelimonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò hypertensian Chronic 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural work 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 05/31 1972892149 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Baltimore, MD Greene St 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

12-04015 Jimmy Manzano Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 17493

miny Manzano		1- For State Registrar	n Maryland 7	Certifica			Mentan		2 U g. No.	12	11470
Physicia ledical Examir	n/	1. Decedent's Name (First, Middle,Last)		MANZ	AND	,		2. Date of Death Month May 27, 20	Day Year	- 1	Time of Death 0855 hrs
redical Exami		4a. Facility Name (if not institution, give		771102		city, Town, or Lo	ocation of Death		4c. County of		
		Johns Hopkins Bayview Me				altimore					
Funeral Director			7. Age	(In yrs. last birtl		Under 1 Year Ionths Days	Hours Mir	_	1961	9. Birthpla Foreign Country	Puecto
Aus	ł	Usual Residence of Decedent  10a. State 10b. County		I0c. City, Town	or Location			<del></del>		100	d. Inside City Limits
Aaryland 28a-f show 1 at once.	اة	MARYLAND BAITIM	core		D	UNDA	ALK				Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eatth and Mental Hygiene. icm 27 is marked other than "natural", or items 23a or 28s-f she traumatic event, the Medical Examiner must be notified at once	Directo	10e. Street and Number 7014 DWNSA	e Rd	Apt	B 10	f. Zip Code	222	10		,5-1	4 .
r death with or items 2	Funeral	11. Marital Status 1 Never Married 2 Married		No	If Yes, s	specify Cuban, M	Mexican, Puerto		White,		Indian, Black,
urs afte tural",		Widowed 4 Divorced  15. Decedent's Education (Specify only	or Dates:  y highest grade comp	olet <b>ed</b> ) 16a. [	Decedent's U	Isual Occupation	n (Give kind of	erto Ric	16b. Kind of Bus	iness/Indu	stry
10re, MD 21215-0036 sgs: I and 2 should be filed within 72 hours nt of Health and Mental Hygiene. it: If item 27 is marked other than "natur other traumatic event, the Medical Exam	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	0	of working life. D		ired)	BAH		•
-003 withir giene. her th	mo.	17. Father's Name (First, Middle, Last)	5+		1	ofess		e (First, Middle, M		17y (	College
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	ည မျ	Miquel	K	(ANZX	NO	10.	-	PIOLIA		LA	rrA
ID 21. should be and Mer 7 is maric even	2	19a. Informant's Name/Relationship (Ty		- /			and Number or	Rural Route Num	ber, City or Town		
ore, MD es 1 and 2 sho of Health and If item 27 is	-	DATIUS J. MA 20a. Method of Disposition	MZANO-		406 f Disposition	(Name of ceme	etery,	Date	20c. Location - C	City or Tow	4D 212 24 m, State
Baltimore, bermit. Pages I a Department of He Important: If ite		1 Nation 2 Cremation 3	Removal from Stat					7-2017	Crouns	svill	e MD
Baltimo permit. Page Department o Important: injury or otl	ł	4 Donation 5 Other Specify: 21. Signature of Euneral Service Licens	ee	ין עוון	22. Name	and Address of	f Facility -	roseph	NZ	ANN	e, MD
	4	23a. Part Enter the disease, or compli	actions that accord to		1265	5 5- 4	ONKII.	Ng ST	BM 40	Me	21224 pproximate Interval
Physician /Medical	7.	failure. List only one cause on each	h line.			ode of dying, su	ici as cardiac c	A Despiratory arre	st, shock, of fleat	, J <sub>E</sub>	Between Onset and Death
Examiner			ramadol I ue to (or as a consec		CIOII					+	
	١,	Sequentially list conditions, if any, leading to immediate	ue to (or as a consec	quence of):						-	
	<u>آ</u>	cause. Enter Underlying Cause (Disease or injury that initiated									
uted ud nd ransit	EX	events resulting in death) Last d.	ue to (or as a consec	quence or).							
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Medical	X UNPENDED	AMENDED 23a,	pt.II,2	7 28a-	-f,per m	ne,g928	6-19-12	sm		
3760 ificate I		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	e of pregnancy 2	Fetal d	eath 3	Ectopic pregna	ancv	23d. Date of d	lelivery Day	Year
ox 61	Physiclan/	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at ti		=	(Specify)					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	چ چ	Part II. Other significant conditions	9 Unknown	but not resulting	in the under	rlying cause give	en in Part I.	23e, Did tol	pacco use contrib	ute to the	cause of death?
, P.O. res that th signed by be detach	g Q	Morbid Obesity;	Hypertens	ion				1 Yes	2 No 3	Probably	/ 4 🗹 Unknown
ords, w requir ts been s should	Completed							24a. Was a autops	sy pri	ior to comp	y findings available pletion of cause of
Reco	Ĕ							perform 1 ✓ Yes 2		eath?  Yes	2 No
Vital Rec ysician: The I his certificate I director, page	å		spital:	t 2 <b>√</b> ER/Ou	strationt 3		f Death (Check		Residence 6	Other:	
of Vil		1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Yea		Time of Injury				ow injury occurred	<u>,                                      </u>	
ion of tending Pheath.	Certification	1 Natural 5 Pending 2 X Accident Investigation	FA 5_27.		known	1 Yes	s 2 X No	drug			scription
Divis lor Ai safter of I Direc	틹	3 Suicide 6 Could not b	28e. Place of Inju	-			lding, etc.			or Rural F unbar	Route Number, City
Hospita 14 hours Funera		4 Homicide	(Specify) Fo	und:Res			and place, and	Dundalk I due to the cause		as stated.	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical	one) 2 Medical Examiner:	On the basis of exam and manner stated.								use(s)
	Ž	29b. Signature and title of certifier				29c. License n			29d. Date signed		Day, Year)
		30. Name and address of person who co	ompleted cause of do	ath (Itom 23a)		O.C.M.			May 28, 201		
			ant Medical Exar		W. Baltin	nore Street,	Baltimore,	MD 21223			
Sta		31. Date filed (Month, Day, Year)	32. Registrar's		1						
Regist	_	JUN V 4 ZUIZ	me B.	park	IGINAL		-				
DHMH 17 Rev 1/20 OCME 2006	<i>J</i> 1	OCME		UK	ISINAL						

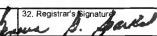
31. Date filed (Month, Day, Year) State HIN O 4 2013 Registrar

Suicide

Homicide 29a. Certifier 1 (Check only

29b. Signature and title of certifie

Pamela E. Southall, MD



or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E. May 31, 2012

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tems 4a,23d,26,29d per doc g928 6-26-12 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mc Gowan Physician/ M 201 Medical 4a. Faciliadur ("neddicigiest Specialist 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore eder Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** -2308 Hours Min **Director** 1 🗆 M 2 🗙 F 624/1945 lelp 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** timore 1 Yes 2 □ No 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 2/2/2 USA 01 items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) sablea A other traumatic event, Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မ Haley thel Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3027 E. St. Dister Battimore Inomasine tedera 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Randallstown 4 ☐ Donation 5 ☐ Other (Specify) 1101 E. North Ave 21. Signature of Funeral Service Licensee 22. Name and Address of Facility larch FIH-Baltimore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition mo Medical resulting in death) Examiner Malnutrition 3yr Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached i Yes No g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: sister's ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home dence 6x Other (Specify) 28a. Date of injury (Month, Day, Year) house Manner of Death
Natural
Accident Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 [ only one) 29b. Signature and tit⊌ of certifie 29d. Date signed (Month, Day, Year) 5-29-12 n who completed cause of death (Item 23a) (Type, Print Name and address of p Registrar's Signatur State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 3. Time of Death Date of Death Physician/ Medical Name (if not institution, give street and **Examiner** 4b. City, Town, cation of Death If Under **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days **Director** 28a-f show 10c. . City, Town or Location the Maryland event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 ☐ No 10e Street and Number 9 10g. Citizen of What Country? Funeral or items 23a filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 ✓ Yes 2 ☐ No
If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Be 17. Father's Name I and 2 should be fill Health and Mental ပ or other traumatic permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other ( Burial 2 Cremation 3 Removal from State Approximate Internal Between Oplish and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to in receipt cause. Enter Underlying Examiner Directo (or as a monsequence or) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Certificate: To Be Completed 1 Yes 2 No 3 Probably Conknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy s certificate has director, page 2 1 Yes 2 25. Was case referred to dical 26. Place of Death (Check only one) examiner? 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manne Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred injury atural 5 Pending 2 🗌 No Investigation Could not be after death Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours aft

To the Funeral Di

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towso Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours Min (Month, Day, Year) Director 1 M 2 X F 8-195 Ls and Irain 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location Director 1 XYes 2 No ore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 01 USA Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 Black 2 X No Specify Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Sumame) arie Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit. or Town, State, Zip Code) Daughter vene Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility F/14- East 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Colorectal Physician/ earcin one disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) signed by the ar Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? DICE Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) 8303 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

4

wo

32. Registrar's Signature

2701 N. Charles

ST

Towson MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 100M Medical lity Name (if not institution, give street an **Examiner** nor Location of Death County of Death N/A More 8. Date of Birth **Funeral** de (In vrs. last birthday) 9. Birthplace (State or Foreign 1**火** M 2 □ F Months Min 213-26-1634 82 Yrs 0772114/1929 MaryTand Director Usual Residence of Decedent show 10b. County with the Maryland notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD N/A Baltimore 1X Yes 2 ☐ No 10e. Street and Number ö 10f. Zip Code 10a. Citizen of What Country? "natural", or items 23a or Funeral 2814 Riggs Ave. 21216 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2X No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than 12th Grade College (1-4 or 5+) filed within and Mental Hygiene. the Bethlehem Steel Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lewis E. Nichols Sr. Mildred Unk Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Donna Waters(daughter) 2814 Riggs Ave., Baltimore, MD 21216 Department of Healtl Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) on-site Crematory 06/05/12 Baltimore, MD Sign tur Funeral Service For Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Part 1. Enter the disease, or complications shock, or beart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any leading to immediate Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and burial-trar resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page orpo 1 ☐ Yes 2 ☐ Mo 1 Yes 2 s case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 1 Yes Certificate: To 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie ted cause of death (Item 23a) (Type, Print) 30. Name and address of

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Catherine Otis 2012 12:10 M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) Days 213-03-6244 **Director** 1 - M 2 - XF 92 Baltimore, MD Nov.1,1919 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Virginia Avenue Apt. 1309 21286 Funeral United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married ģ Yes Maryland 21215-0036 1 ☐ Yes 2X No Specify. White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Banking Teller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Carmella Carbone Charlie Magenta 19a. Informant's Name/Relationship (Type, Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 1636 Ceddox Street Baltimore, MD 21226 Kimberly DeLuca daughter Baltimore, June 06, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, MD Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer Cemetery 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Redeemer 2012 | Date of Red Donation 5 Other (Specify) 2012 Signature of Funeral Service Licensee 1 du Services Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cexebrovascular Phosician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of physician and the burial-transit that initiated events Hospital or Attending Physician: The law requires that the death certificate be exect to hours after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 menths? Day Month Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bhasia 1 Yes 2 No 3 Probably 4 M Unknown After this certificate has been signeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 KNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗷 No Other: bue ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after death.

I Director: After to a lin by the funeral injury work? 1 ☐ Yes 2 ☐ No 1 K Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital within 24 hours a To the Funeral C

State Registrar

only one) 29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABBAS

31. Date filed (Month, Day, Year)
JUN 0 4 2012

6701 N Charles Street

32. Registrar's

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year,

St. 4105 Baltimore, MD 21204

15 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D72139

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZOIZ 920 M Medical a. Facility Name (if not institution, give street and number) 4b. City, Examiner lown, or Location of Death 4c. County of Death ocial Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Country Director 1 □ M 2 🛣 F 10-11-1948 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any njury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces?. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Completed by Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 ☑ Widowed 4 □ Divorced Specify: Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Caucation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Kins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Departion 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility - East 1. Enter the disease, or complications that cause the ck, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immeriate Cause (Final Onset and Death Physician/ di e se or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or in July that initiated events Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 X 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 \( \sqrt{No.} \) 1 Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one examiner? Hospital 1 🗌 Yes 2 Other: မှ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deat Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely within 2 To the I 29b. Signature and title of certifier 29c. License numbe lima Ray, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 4 2012 Registrar